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Chemist&Druggist
The Newsweekly for Pharmacy

30 November 2002

Realistic plans for drugs paraphernalia

Strong support for pharmacy in Scotland

ETP pilots may be allowed to run into 2003

LPS – where are we going from here?

Many aspire, but only one succeeds

- Ibuleve is the undisputed **brand leader** amongst topical painkillers, with 54% market share and still growing*
- Pharmacists **sell more Ibuleve** than all other topical NSAIDs put together
- Ibuleve is committed to **pharmacy only** sales
- Ibuleve has spent **over £35m** on national TV and press since launch
- Ibuleve provides **maximum strength pain relief** to more people than any other painkilling gel
- **20 million packs** of Ibuleve sold through pharmacies, consumers just keep coming back for more

No.1 - by miles and miles

ibuprofen

*Source: IRI infoscan 52 weeks to end Sept 2002 for Pharmacy Topical NSAID sales.

IBULEVE Trademark and Product Licence held by Diomed Developments Ltd, Hitchin, Herts, SG4 7QR, UK. Distributed by DDD Ltd, 94 Rickmansworth Road, Watford, Herts, WD18 7JJ, UK. **Directions (Ibuleve Gel and Ibuleve Sports Gel):** Lightly apply a thin layer of the gel over the affected area. Massage gently until absorbed. Wash hands after use. Repeat as required up to three times daily. **Directions (Ibuleve Spray):** Apply 5 - 10 sprays (1 to 2 ml) and massage into the skin over and around the painful site. Wash hands after use. Repeat 3 to 4 times daily **Directions (Ibuleve Mousse):** Apply 1 to 2 g (1 to 2 golf-ball sized quantities) of mousse and massage into affected areas. Wash hands after use. Repeat 3 to 4 times daily **Directions (Ibuleve Maximum Strength Gel):** Lightly apply 2 to 5 cm of gel (50 to 125 mg ibuprofen) to the affected area. Massage gently until absorbed. Wash hands after use. Repeat as required up to three times daily **Indications:** For the relief of backache, rheumatic and muscular pain, sprains and strains. Ibuleve is also for pain relief in non-serious arthritic conditions. **Contra-indications:** Not to be used if allergic to any of the ingredients, or in cases of hypersensitivity to aspirin, ibuprofen or related painkillers, especially where associated with a history of asthma, rhinitis or urticaria. Not to be used on broken skin, or where there is infection or other skin disease. Not to be used during pregnancy or lactation. **Precautions:** Not recommended for children under 12 years without medical advice. If symptoms persist, consult a doctor or pharmacist about continued treatment. Patients with asthma, an active peptic ulcer or a history of kidney problems should consult their doctor before use, as should patients already taking aspirin or other painkillers. Interaction with blood pressure lowering drugs may occur, but is very unlikely. Keep away from the eyes, nose and mouth. Keep all medicines out of the reach of children FOR EXTERNAL USE ONLY **Side-effects:** In normal use, side-effects are very rare, but may occasionally include allergic or localised skin reactions in susceptible individuals. Ibuleve Spray and Ibuleve Mousse are FLAMMABLE. Keep away from flames. **Legal Category:** P **Packs:** Ibuleve Gel (PL 0173/0060) - 30g, RSP £3.89 (£3.31 exc. VAT) and 50g, RSP £5.39 (£4.59 exc. VAT), Ibuleve Sports Gel (PL 0173/0060) - 30g, RSP £3.95 (£3.36 exc. VAT), Ibuleve Spray (PL 0173/0160) - 35ml, RSP £4.75 (£4.04 exc. VAT), Ibuleve Mousse (PL 0173/0168) - 75g, RSP £7.95 (£6.77 exc. VAT) and 125g, RSP £10.60 (£9.02 exc. VAT), Ibuleve Maximum Strength Gel (PL 0173/0176) - 30 g, RSP £4.95 (£4 21 exc. VAT) and 50g, RSP £6.95 (£5.91 exc. VAT).

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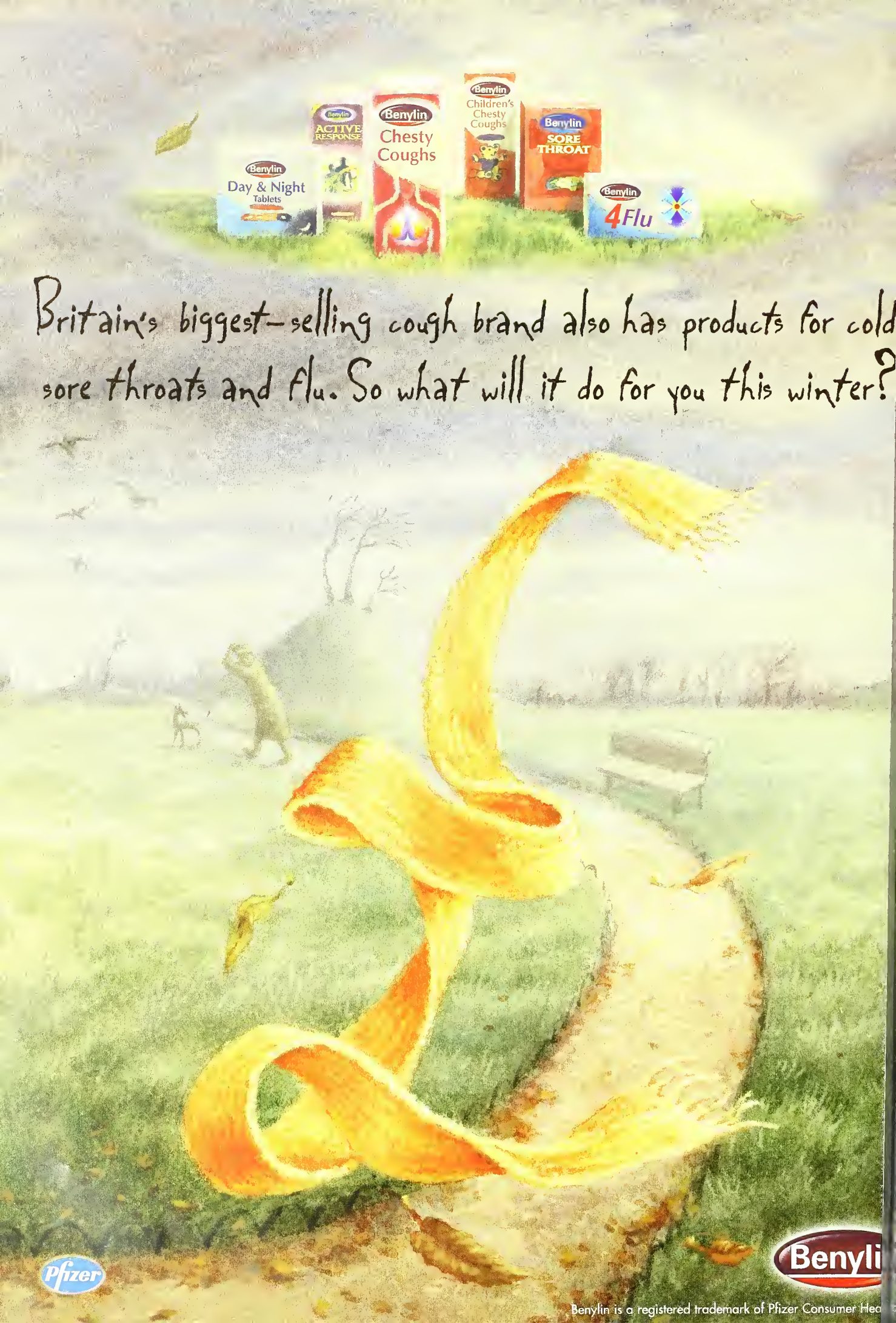
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This week

Pharmacy Update

Regulars

Features

LEGISLATION

Paraphernalia supply may be allowed

Pharmacists may be legally allowed to supply drug users with paraphernalia next year depending on the outcome of a Home Office consultation.

Proposals to Make Lawful the Supply of Specific Items of Drugs Paraphernalia to Drug Users seeks public views on the supply of water for injections, swabs, spoons, bowls and citric acid for harm minimisation purposes. It does not propose to allow the supply of other articles such as filters, tourniquets and cigarette papers.

The Misuse of Drugs Act 1971 currently makes it an offence for a person to supply any article, except a syringe and needle, where they believe it may be used to administer an unlawful drug.

Pharmacists and drugs agency staff sometimes supply drug users with paraphernalia in order to reduce the risk of infections. The Government recognises that this situation is unsatisfactory and that drugs workers are putting themselves at risk of prosecution. In reality, the police and the Crown Prosecution Service do not prosecute, as it would not be in the public interest.

The Advisory Council on the Misuse of Drugs was asked by the Government to consider and advise on the harm reducing benefits of paraphernalia. It also recommended that:

- citric acid should only be supplied by pharmacists and others who have had appropriate training on its effects and the quantities to be used, otherwise it may lead to 'citric burns'
- an amendment to the POM order may be necessary to enable pharmacists or nurses working in drug treatment services to supply water for injections
- there is little evidence that tourniquets have any harm-reducing benefits
- further research is needed into the benefits of filters but in the meantime they should not be made lawful.

The Government has accepted the ACMD's recommendations in accordance with its recently stated commitment to strengthen the harm minimisation focus within the Drugs Strategy. The changes would apply to England, Wales and Scotland.

The consultation says that the proposals should not create any additional burdens on pharmacies. Where the Government or a PCT funds a needle exchange scheme, then it is anticipated that they would be able to supply extra articles from existing resource allocations. And if pharmacies sell articles of paraphernalia, the proposals should lead to an increase in trade and therefore an additional source of income.

Comments should be sent to Mr Naim Siddiqui, Communities and Law Enforcement Drugs Unit, Home Office (Room 243), 50 Queen Anne's Gate, London SW1H 9AT by February 14, 2003.

- The Home Office is considering a recommendation by the ACMD that nurses working in A&E departments or coronary care units should be allowed to supply and administer controlled drugs under patient group directions. A public consultation would be held if the Home Office decided to accept this idea.

For more information:

www.homeoffice.gov.uk

E-mail: *Naim.Siddiqui@homeoffice.gsi.gov.uk*

Tel: 020 7273 3474.

The Ulster Chemists' Association raised £3,700 for Victim Support at its annual dinner in Belfast last Saturday. Some 320 guests mingled with 'local television celebrity' Hillary Hamilton of Holywood, who metamorphosed into the 'real' comedienne Nuala Mckeever, special guest of UCA president Siobhan O'Reilly. Ms O'Reilly chose Victim Support as her charity, pointing out that pharmacists and pharmacy staff have increasingly been the victims of attacks, raids and robberies. Among the items put up for a charity auction was a pair of tickets to see a Manchester United match which raised £500. A fire-eater's act was postponed, apparently, although whether that was due to the firemen's strike or the rather heavy downpours outside was unclear. Pictured are Ms O'Reilly, right, presenting a bouquet of flowers to Ms McKeever who hosted the auction

LEGISLATION

MCA proposes new standard for blister packs

A new standard for the packaging of paracetamol, aspirin and iron supplements in blisters has been proposed by the Medicines Control Agency.

In its consultation document, *MLX 291*, the MCA is proposing the implementation of the British Standard on child-resistant packaging for non-reclosable packaging for pharmaceuticals (BS8404).

Announcing the initiative on Tuesday, the Department of Health said: "Although the British Standard for reclosable containers (bottles etc) for pharmaceuticals has been in existence for many years, there has been no similar standard for blister or strip packs."

While BS8404 sets out what constitutes child resistance, how it is met would be up to the manufacturer, says the DoH.

"One example would be to attach self-adhesive covers to the foils on blister packages, making it impossible to pop out the pill until the cover has been peeled back."

Proposed exemptions from the regulations include:

- effervescent tablets containing not more than 25 per cent of aspirin or paracetamol by weight
- medicinal products which are not intended for retail sale or those supplied on prescription.

However, the regulations will still allow patients to receive these medicines in a non child-resistant container, if they personally make a request to a pharmacist or doctor.

- In addition, the Committee on Safety of Medicines has advised that the requirement for reclosable child-resistant packaging should be extended to include medicines containing in excess of 24mg of elemental iron per unit dose and liquid paracetamol preparations.

Comments on the proposal should be send to Amanda Lawrence, Medicines Control Agency, Room 14-152 Market Towers, 1 Nine Elms Lane, London SW8 5NQ, to arrive by February 18, 2003.

For more information:

www.mca.gov.uk

Pictured inspecting the guide are health minister David Lammy and Joanne Shaw, director, Medicines Partnership

Minister backs review strategy

Health minister David Lammy (pictured left) has welcomed a new guide to implementing medication reviews.

Speaking at the launch of *Room for review* this week, he said a key aim of medicines management is to help patients understand their medicines and be participants in their own treatment.

Patients are becoming less likely to accept a passive role as health care recipients and must become partners with health professionals, he said.

Dr June Crown, chairman, Pharmacist Preseribing Task Group, said medication review was a way to use pharmacists' skills more effectively in the health service.

She hoped the reviews would look at "sins of omission" as well as "sins of commission" (polypharmacy).

Besides sifting out unneeessary medieation, the reviews should also examine how elderly people might benefit from additional treatments such as low dose aspirin, statins or calcium supplements.

This would have enormous humanitarian gains in terms of reducing morbidity and would have implications for the quality of long term care, she said.

The guide is published by the Task Force on Medicines Partnership and the National Collaborative Medicines Management Serviees Programme.

It describes different levels of medication review and suggests how to establish a review process. Copies of a 'Briefing' summary have already been sent to community pharmacists; extra copies are available from Clare MeKenzie on 020 7572 2474.

The full report – *Room for review – a guide to medication review: the agenda for patients, practitioners and managers* (£15) is available on 01491-829272.

For further information:

www.medicines-partnership.org/medication-review

SCOTLAND

Scottish pharmacies' untapped potential

Better use of community pharmacies in Scotland could potentially improve the health of the nation, according to a survey by the Scottish Consumer Counеil.

But this will only be achieved by getting the right messages over to the public about the range of services pharmacists can provide, it concluded.

Graeme Millar, current SCC chairman and former RPSiS chairman, said: "It is clear that the location of community pharmacies is a real strength. Pharmacies provide health advice and assistanee on the high street, and this is something that the Scottish Executive rightly wants to build on.

"The fact that so many people are comfortable seeking health adviee from pharmacists is another plus and shows that pharmacists are seen as skilled professionals who are also approaehable.

"What is more worrying about our findings is the lack of recognition among many people that pharmaeists are part of the NHS. This misconeeption needs to be addressed if the aims of the [pharmacy] strategy in extending the services available in pharmacies are to be achieved."

The Scottish Pharmaceutical Federation, which welcomed the survey, said the Offiee of Fair Trading must take sueh public support into account in its eontrol of entry investigation.

Ian Johnstone, SPF chairman, said: "We have warned the Executive that a decision to lift the regulations will seriously impact on their ambitious health strategy. A locations free-for-all is not in the interests of NHS Scotland or the patients we deal with daily."

The survey, funded by the Seottish Executive Health Department, collected information from 1,044 consumers. The data will help implement the Scottish pharmacy strategy, *The Right Medicine*.

For more information:

www.scotconsumer.org.uk

Key findings from the survey, in which 1,044 adults were interviewed in their homes, are:

- a high level of usage of community pharmacies, with 36 per cent of people visiting at least once a month, and a further 47 per cent at least once every three months
- nearly 75 per cent said they would feel comfortable or very comfortable about approaching their pharmacist for medical advice, and 43 per eent had done so in the past year
- 61 per cent agree that pharmacists should be able to authorise repeat prescriptions, 41 per cent are in favour of pharmacists carrying out health checks and 37 per cent back pharmacist-run smoking cessation clinies
- only 51 per cent saw pharmacists as part of the NHS
- 90 per cent found local pharmacies to be convenient, and almost two thirds use the same pharmacy for their health needs.

Baby involved in Oramorph mix up

Lloydspharmacy has launched an investigation after Oramorph was dispensed for an eight-month-old baby instead of orciprenaline syrup.

Lloydspharmacy's deputy superintendent, Nick Mortimer, said: "A prescription was issued for amoxycillin syrup and oreiprenaline syrup. However, Oramorph solution was dispensed in error, although none was taken."

However, it is understood that an identical error occurred previously in the same Stevenage branch of Lloydspharmacy in January 2000, when a four-month-old baby was dispensed Oramorph instead of orciprenaline.

Although different pharmacists were on duty on the two occasions, the prescriptions were issued by the same GP. Reports suggest that the latest prescription was hand written.

"Lloydspharmacy is currently conducting an in-depth investigation to determine exactly what occurred. We are also aware the Royal Pharmaceutical Society is conducting its own investigation, and we are co-operating fully with this," said Mr Mortimer.

Stephen Lutener, the Society's head of profcssional conduct, said: "We are concerned to hear of the alleged error involving the supply of Oramorph on a prescription for an infant, and have been in touch with the parent so that we can start our investigations.

"While the Society is unable to discuss matters under investigation, I can say that immediately we became aware of the incident, one of our pharmacy inspectors visited the pharmacy to review its dispensing systems.

"The main purpose of that visit was to establish whether there are any serious shortcomings in the systems in the pharmacy. Interviews with the pharmacists involved will follow, once the full evidence has been obtained from the parents."

Lloyspharmacy has selected its Trench Road branch in Londonderry, Northern Ireland, as its Pharmacy of the Year. The branch was presented with a cheque for £1,500 by Lloysdpharmacy's managing director Mike Ward and GlaxoSmithKline Consumer Health's sales director Peter Hinckley. In second place came the Scunthorpe Asda branch, North Lincolnshire, and third was the Wychbury Medical centre in Stourbridge, Gloucs. Branches had to submit a record of their achievements in scrapbook format to demonstrate how they had achieved their business plan. Pictured are, from the left, back row: Peter Hinckley, GSK sales director and Lloydspharmacy managing director Mike Ward; front row from left: pharmacy dispenser Amanda Gillespie, supervisor Noreen Doherty, pharmacist manager Liz Brolly and area manager John McArdle

Questiontime

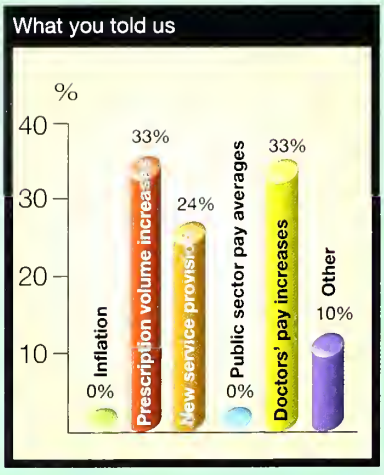
in association with UniChem

Last week we asked you: "In light of the Government's approach to addressing pay inequalities in the public sector, do you think that the pharmacy pay settlement should be in line with:" You replied (see right):

This week's question: If the proposals to allow easier access to drug-taking paraphernalia are accepted, what change in the level of drug-taking related harm do you think there will be:

- An overall reduction
- An overall increase
- No change to the current levels

You can record your vote on our website: *www.dotpharmacy.com*. You have until noon on December 3 to east your vote. We will publish the results in *C&D*, December 7.



EUROPE

Strasbourg adopts herbal medicine proposals

The European Parliament has adopted a resolution to ensure traditional herbal medicinal products meet basic quality and safety standards.

Last Friday, MEPs voted in favour of a new licensing system for traditional herbal medicines, whereby the ingredients in herbal products will be subject to standards on quality and quantity.

However, established herbal medicines can gain an automatic licence if they can "prove their safety through 'traditional use', which means that they must have been on the market for 30 years - 15 years of which they must have been used in Europe," says the Parliament.

Herbal products will also have t include information for consumer on what the ingredients do, along with details about adverse effects, and food and drug interactions.

MEPs also called for a Committee on Herbal Medicinal Products to be set up. It would be responsible for classifying such products and listing their pharmacological and toxicological effects, as well as therapeutic indications, routes of administration, daily doses, adverse effects and any interactions with drugs, alcohol and foods.

The Medicines Control Agency said the position taken by the European Parliament was "fully consistent with the negotiating stance that the Government has taken after extensive discussions with the UK herbal sector".

For more information:

www.europarl.eu.int

GOOD DEED ON GOOD FRIDAY

A London hospital was in desperate need of erythromycin for a patient undergoing life-saving heart surgery. The problem was it was Good Friday. They phoned IVAX. Being a public holiday, a member of the security staff took the call. Realising the urgency of the situation, he called Neil Marsden, IVAX distribution manager. Neil raced to the warehouse from his home in Essex, located the drugs and arranged for a motorcycle courier to speed them to the hospital. So it's not just our drugs that save lives. It's the dedication shown by our people too.

IVAX

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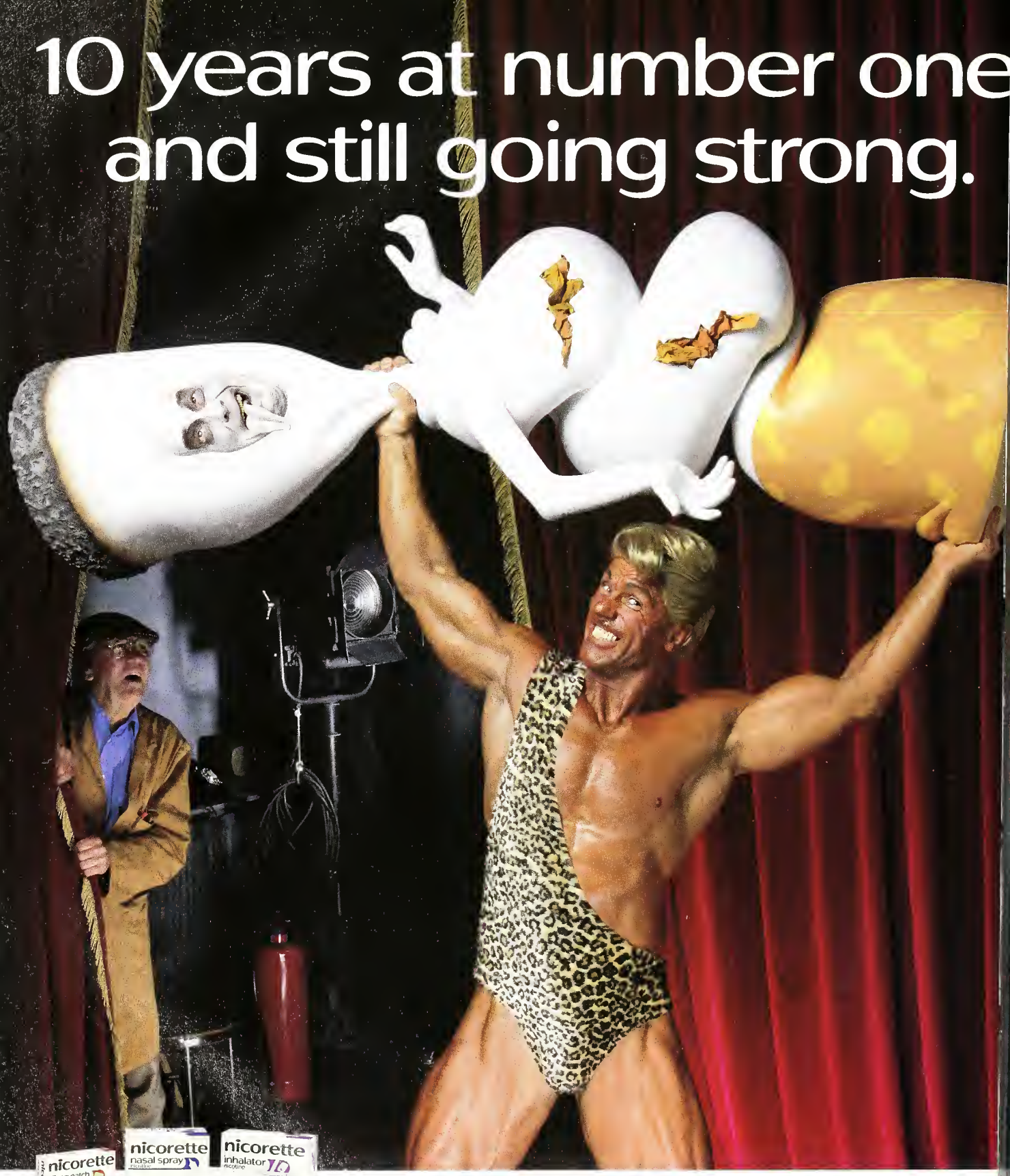
10 years at number one and still going strong.



It's no wonder Nicorette is still the number one selling Nicotine Replacement Therapy brand. As inventors of the category, Nicorette offer the products, support and customer promotions responsible for driving growth in the NRT market for the past 10 years. What's more, Nicorette has helped more smokers beat cigarettes than any other NRT brand[1].

So to see your sales go from strength to strength, make sure you have the complete range to suit every smoker in stock today.

nicorette
nicotin

twice the chance of success*

*Compared to willpower al

Minister backs early start for pharmacist prescribing

Health minister Lord Hunt has highlighted the prospect of pharmacist and nurse prescribing early next year.

In a visit to Guy's Hospital, London, the minister said that while both community and hospital pharmacists will be involved, it will initially be mainly hospital pharmacists who prescribe. However, community pharmacists working in primary care with GPs, and therefore with access to patients records, will also be included.

The aim is to have 1,000 pharmacists and 10,000 nurses trained by the end of 2004, but preferably more, he added.

Although the legislation has yet to be put before parliament, a DoH spokesman said that as no primary legislation is required, a statutory instrument could be tabled relatively easily. This was likely to happen early next year. Training will initially be through the 40-50 centres that currently train nurses for independent prescribing.

Lord Hunt chose to promote the role of prescribing by visiting the hospital's anti-coagulation clinic. While supplementary prescribers may expect to specialise, the regulations will allow pharmacists to prescribe all types of medicines (except controlled drugs) so long as this is under agreed clinical protocols.

In Scotland, health minister Malcolm Chisholm emphasised that training will be "carefully designed to ensure patient safety" and will allow pharmacists and nurses to prescribe medicines following diagnosis of a patient's condition.

"The doctor and the supplementary prescriber will agree a clinical management plan, setting out how and when nurse and pharmacist prescribing can take place for that particular patient. These arrangements will also be agreed with the patient.

"Patients who are most likely to benefit are those who suffer from chronic conditions, such as diabetes and asthma ...the changes will also enable the supplementary prescriber to adjust the dosage, frequency and formulation of the medicines within the limits set by the clinical management plan."

The ministers' statements have been welcomed. RPS in Scotland chairman David Thomson said: "The very positive response to the pilot schemes in Arbroath and Patna is evidence that by better utilising the skills of pharmacists, real improvements in the provision of services to the public can be made."

NPA chief executive John D'Arcy said: "Extending prescribing responsibilities to pharmacists will enable them to work in partnership with GPs to improve patient treatment and care, in particular for patients with chronic and enduring conditions. This will help patients get the right medicines, at the right time, and in a more convenient way than ever before."

Pictured is Guy's and St Thomas' NHS Trust's chief pharmacist, Tony West, (left) discussing medicines provision with health minister, Lord Hunt

The NPA has relaunched its NVQ Level 3 Pharmacy Services training package with support from Eldon Laboratories

For more information:

NPA Education & Training Dept,
Tel: 017827 832161 ext 3475.

Condom usage among the young causes alarm

Young people are the most reluctant to use a condom when embarking on a new sexual relationship.

The 2002 Durex Global Sex Survey found that 46 per cent of 18-20-year-olds had sex without a condom with a new or different partner in the last year.

This compares with 61 per cent of the British population as a whole who used condoms to protect against sexually transmitted infections or unplanned pregnancy.

Commenting on the findings, Durex marketing manager Amanda Tucker said: "It's alarming so many people are risking their health... we have to acknowledge that many teenagers are going to have sex and it's vital that they understand the importance of using a condom to protect themselves and their partner.

"We hope this research will continue to put the vital safer sex message onto the map."

For more information:

www.durex.co.uk

IT

ETP pilots could continue to run into next year

The three electronic transfer of prescription (ETP) pilots may continue beyond the end of the official assessment period on December 31, it has emerged.

The three consortia (TransScript, Flexiscript and Pharmacy2U) have been invited to submit proposals on how the pilots could remain live into next year.

The question of whether the pilots would have to be discontinued while the Department of Health awaits the final report and decides on the eventual model had been raised repeatedly.

Discussions on the subject are currently ongoing between the three consortia and the DoH as the December 9 deadline for submission of the proposals approaches.

Meanwhile ETP appears to be gathering momentum as the total number of prescriptions transmitted via the three pilots (as at November 15) reached almost 22,500. Nearly 8,500 of these were sent in the week between November 7 and November 15 alone.

TransScript, whose viability had previously been called into question, said that two more GP surgeries had recently gone live and showed a "strong stream" of scripts.

A spokeswoman for Flexiscript added that it had seen a steady increase in the number of prescriptions sent electronically.

A strategic outline case for ETP has been agreed by the ETP Programme Board, which is currently made up of policy representatives from the DoH and colleagues from the NHS Information Authority.

It is, however, expected that in time, key stakeholders from within the NHS as well as GP and pharmacy professional organisations will also be included.

The DoH expects ETP to be the vehicle for delivering 'a significant proportion' of a national prescriptions service (NPS) as described in the Governments' IT strategy *Delivering 21st century IT support for the NHS*.

The IT strategy is aiming for a 50 per cent implementation of the NPS by December 2005, with full implementation completed by December 2007.

But, as the results from the latest *C&D Quarterly Business Trends Survey* showed, pharmacists are sceptical that these targets can be met.

Only one in five of the pharmacists questioned was confident that a 50 per cent implementation can be achieved within this timeframe, while 74 per cent were not. As for meeting the 2007 deadline for full implementation, the picture was even worse, with only 15 per cent considering it achievable.

Phoenix Healthcare Distribution is increasing the product range carried by its Glasgow depot to such an extent that an additional conveyor belt and racking system is to be installed. Phoenix found that 500 of the 10,500 lines carried at the depot were in such short demand that they could be taken out. Meanwhile orders for 2,500 products could not be fulfilled from Glasgow and had to be switched to other depots. "Although some of these are slow moving products, we decided that in order to improve our service to our customers these products should now be stocked in Glagow," said David Cole, Phoenix's chief executive. The Glasgow depot will be able to supply the new products from December 1

INDUSTRY

Pfizer/Pharmacia merger delayed

The European Commission has delayed its decision over the intended merger between pharmaceutical giants Pfizer Inc and Pharmacia Corp.

The Commission was due to announce its verdict on Friday (November 29) but has asked the two companies for further information.

The clock will start ticking again once the additional information has been supplied. The new deadline for the Commission's verdict is November 29 plus the days it took Pfizer and Pharmacia to respond to the Commission's request.

A Commission spokeswoman said that the two companies were expected to react quickly as their aim had been to complete the merger by the end of the year.

Meanwhile the two companies will hold special shareholder meetings in Wilmington, Delaware (USA) to vote on the merger on December 6 (Pfizer) or December 9 (Pharmacia).

FINANCE

PMI to offer in-house car insurance

Pharmacy Mutual Insurance will be offering pharmacists car insurance products directly, after the company was given authorisation as a motor insurance underwriter by the Motor Insurance Bureau.

Two new PMI products, 'car' and 'commercial vehicles', will become available in the new year.

There will be three levels of car insurance to choose from – third party, third party fire and theft or fully comprehensive.

The basic package includes access to approved repairers, breakdown assistance, free foreign use for up to 90 days, unlimited personal injury and property damage liability, free legal expenses of up to £50,000 per incident and an advice hotline.

It also features business use of the car for employees and a no-claims discount of up to 65 per cent.

The 'commercial vehicle' policy insures the holder for carriage of own goods only and allows up to five drivers to be named. Property damage is covered for up to £5 million and £300 for personal and business goods.

Pharmacists can upgrade to third party fire and theft or fully comprehensive. Maximum vehicle value under the third party fire and theft policy is £3,000, rising to £30,000 for fully comprehensive.

For more information:

Tel: 0800-216118.

LEGAL

Kent loses court case

Kent Pharmaceuticals has lost its High Court challenge against the Serious Fraud Office, claiming that the SFO's dawn raids on the company *(C&D April 13, p6)* amounted to a violation of fundamental human rights.

Kent, along with Generics UK, IVAX UK, Ranbaxy (UK), Goldshield and Regent-GM, was targeted by the SFO as part of an investigation into an alleged conspiracy to restrict the supply and fix prices of generics. The company denies any wrongdoing and no charges have been brought so far.

ComingEvents

DECEMBER 2

NICPPET
Women's Health, at the NICPPET Resource Centre, School of Pharmacy, Belfast, 10am-5pm.

East Kent Branch RPSGB
Pharmacist Prescribing, by Dr June Crown, at the Howfield Manor Hotel, Chartham Hatch, Canterbury, 7.30 for 8pm.

DECEMBER 3

NICPPET
Prescribing Foundation Support Training III, at the Oaklin House Hotel, Dungannon, 7.30pm.

Oxfordshire Branch, RPSGB
Continuing Professional Development, with Ian Simpson, chief executive CPP, at the George Pickering Postgraduate Medical Centre, John Radcliffe Hospital, Oxford, 8pm.

Northern Scottish Branch, RPSGB
Getting Started in Pharmacy Practice Research, by Dr Catherine Sinclair, 7.30pm.

DECEMBER 4

NICPPET
Prescribing Foundation Support Training III, at the Fitzwilliam International Hotel, Antrim, 7.30pm.

DECEMBER 5

NICPPET
Interpersonal Skills in Palliative Care, at the NICPPET Resource Centre, School of Pharmacy, Belfast, 10am-5pm.

FINANCE

Stakeholder pensions failing to attract members

Stakeholder pensions are still failing to make a major impact on the 'savings gap', according to the Association of British Insurers.

While more than 1.15 million policies have been sold to date, the ABI found that more than 90 per cent of employer-designated schemes had no members at all.

The organisation blames the apparent lack of success of stakeholder pensions, at least in part, on the low percentage of schemes with employer contributions (9 per cent).

There seems to be a correlation between employer contributions and uptake, with the latter rising from just 13 per cent (no employer contribution) to 69 per cent in schemes that include a 5 per cent employers contribution.

Meanwhile 30,000 companies are still failing to designate a stakeholder pension scheme and face a potential £50,000 fine.

However, OPRA, the pensions regulator, denied press reports that it had started to come down heavily on companies failing to comply with the legislation.

Opra's spokesman Nick Edmans insisted that there had not been a change in tactic and that employers would be given a second chance.

"Yes, we are looking for compliance, but if an employer is taking steps (towards designating a scheme) after we contacted them, we won't pursue it further."

But at the same time Mr Edmans warned people against complacency. "We will use our powers if we find serious resistance – we won't allow people to ignore the legislation," he said.

But pointing to a compliance rate of above 90 per cent, he added that, so far, Opra had not needed to use them.

Meanwhile, Trefor Williams, the NPA's head of business support, said that nearly a third of all NPA members have designated the association's stakeholder pension scheme, provided by Scottish Widows.

He agreed, however, that the number of employers taking up the offer of a stakeholder pension was significantly lower.

"This seems to support the general view that workers are not viewing stakeholder with any enthusiasm," Mr Williams added.

UniChem Ltd, which operates a stakeholder pension scheme through NPI, said that the response had been very good. The wholesaler is awaiting up to date figures from the NPI.

So far there have been no reports of pharmacists being fined.

INDUSTRY

Roche and Antisoma in drug alliance

Swiss pharmaceutical giant Roche and British biopharmaceutical company Antisoma have formed a strategic alliance giving Roche the exclusive worldwide rights to Antisoma's cancer portfolio.

Roche will make a down-payment of $37 million (£23.6 million), principally for the research already done by Antisoma on developing the products. Roche will also cover any further development and marketing costs.

Roche has invested an additional £4.15m to secure approximately a 10 per cent stakeholding in Antisoma. It will also make further cash payments and royalties.

Antisoma's cancer portfolio, which is said to complement Roche's already strong oncology franchise, includes Pemtumomab for ovarian cancer, which is currently in phase III clinical trials, as well as three further cancer treatments in phase I human trials.

Resource Partners, the financial services group for the healthcare sector that includes Pharmacy Partners, has won the accolade of 'Most Successful New Entrant' at the first ever Business Finance Awards. Resource Partners first came to pharmacists' attention through its FastFlow system of releasing expected NHS payments early, marketed through its Pharmacy Partners subsidiary. Pictured, from the left, are: David Grosse, Resource Partners' director of business development, Robert Hare, Bank of Scotland, which sponsored the award, and Ian Patterson, Resource Partners' chairman. The event, which is to be held annually, is run in association with the National Association of Commercial Finance Brokers

FINANCE

GSK pay row

GlaxoSmithKline appeared read to back down from an estimated $21 million (£13.2 million) pay package for its chief executive, Jean-Pierre Garnier, in the face an alleged shareholder revolt.

If granted, the new pay packa would virtually double Mr Garnier's remuneration from an estimated £6m plus in 2001.

GSK said it "remains committed to the policy of aligning its incentive plans with those of its global pharmaceutic peer group. However, after takir account of shareholder views th company has decided to postpo a decision and will take further time to consider the way forwar

HEADONISTIC

CONTAINS IBUPROFEN FOR HEADACHES

ibuprofen

uct Information for Nurofen Recovery: Each tablet contains 200mg fen PhEur. **Indications:** For the relief of heodaches and migroine. **Dosage and nistration:** Ploce a tablet on the tongue, ollow it to dissolve and then swollow; er required. Adults ond Children over 12 years: Initial dose 2 tablets, then if necessary tablets every 4 hours. Do not exceed 6 tablets in any 24 hours. Not for use by n under 12 yeors of age. Elderly: No special dosage modifications are required, renal and hepotic function is impaired, in which cose dosage should essed individuolly. **Contraindications:** Hypersensitivity to any of the constituents, , or other NSAIDs. Patients with existing, or o history of, peptic ulceration. Patients with ry of bronchospasm, rhinitis, or urticaria associoted with aspirin or other NSAIDs. **utions and Warnings:** Caution is required in patients with renal, cardiac and impairment. In patients with renal impairment, renal function should be monitored may deteriorate following the use of any NSAID. Bronchospsam may be precipitated nts suffering from, or with a previous history of, bronchiol asthma or allergic disease. toking any other poin reliever, regular treatment and pregnant women shauld only toke Nurofen Recovery tablets after consulting their doctor. The elderly are at increased risk of the consequences of adverse reactions. Undesirable effects may be minimised by using the minimum effective dose for the shortest possible durotion. **Side Effects:** Hypersensitivity reactions have been reported following treatment with ibuprofen. These may consist of (a) non-specific allergic reaction and onaphyloxis, (b) respiratory tract reactivity comprising of asthma, aggravoted asthma, bronchosposm or dyspnoea, or (c) assorted skin disorders, including rashes of various types, pruritus, urticaria, purpura, ongiodema and, more rarely, bullous dermotoses (including epidermal necrolysis and erythema multiforme). Gastraintestinal – Abdominol pain, nausea and dyspepsia. Occasionally peptic ulcer and gastrointestinol bleeding. Renal – Papillary necrosis which con lead to renal failure. Others – Hepatic dysfunction, headache, dizziness, hearing disturbance. Rarely thrombocytopenia. **Product Licence Number:** PL 00327/0130. **Licence Holder:** Crookes Healthcare Limited, Nottingham NG2 3AA. **Legal Category:** GSL (up to 16 tablets), P (more than 16 tablets). **Price:** £2.65 for 12 tablets. **Date of Preparation:** November 2002.

CROOKES HEALTHCARE

Comment from the Editor

Governance is a feature of the news this week. A dispensing error for a baby has involved drugs which, while very different in name and nature, could sufficiently resemble each other in outline when hand written by the doctor. Bad press like this should remind pharmacists to remain focused on the profession's core activity – that of dispensing. While developing new service areas is all well and good, the basics must be maintained at a suitably high standard, otherwise the public will justifiably lose confidence in the profession. As a Scottish survey has demonstrated this week, that would be a great shame, as the Scottish Consumer Council has again found overwhelming support for pharmacy and pharmacists.

Patient safety has also come under the spotlight with the latest proposals for medicines packaging. While the plans to introduce unspecified child-resistant packaging for blister packs of aspirin, paracetamol and iron products is to be welcomed, one may argue that this is too little, too late. It would have been better if health ministers had the bottle to introduce such safety measures across all medicines packaging.

"About time, too" might also be said of the second consultation this week, on the supply of paraphernalia associated with illicit drug taking. The Home Office proposals finally go some way to recognising what has become a regular part of many pharmacists' day-to-day practice. Technically, pharmacists break the law in supplying citric acid for drug injectors. However, the law has held off, recognising that the public health consequences could be far worse than if the law were rigorously applied. For a profession that is bound by its code of ethics to promote the safety and wellbeing of any of its patients, the proposed changes should come as a welcome relief.

The basics must be maintained at a suitably high standard, otherwise the public will justifiably lose confidence

Yourviews

A little learning can be a dangerous thing, warns Liverpool LPC secretary Jeremy Clitherow

Don't send a boy to do a man's job

When people stray outside their area of expertise and experience things invariably go wrong. Let me give some pharmacy-related examples.

On October 31, Merseymart reported that local GP practice staff were to be trained to dispense medicines more efficiently, and that local MP Maria Eagle supported the scheme *(C&D November 16, p5)*.

This resulted from a press release given to the 'freebie'. This is no local small time news sheet. The South Liverpool edition alone has a circulation of 55,371 copies per week. Its readers were led to believe that the local pharmacies were below standard – why else would you want more efficient dispensing? Those dedicated community pharmacists who had been servicing their local neighbourhoods were rightly incensed at the implied criticism.

The local pharmaceutical committee immediately sent off an irate letter to the South Liverpool PCT, demanding that the record be put straight. The PCT, frightened of upsetting a local politician by "putting her right", has done nothing. Nor has Maria Eagle done anything to make good the damage, no doubt hoping the matter will blow over.

Jeremy Clitheroe: when will PCTs learn?

The damage done to the reputations of the pharmacies in the five affected areas is incalculable. An immediate apology should have gone to all the Liverpool contractors from the PCT, indicating the Trust at least was aware of the implications of the newspaper report. To my certain knowledge, none of this has happened.

And another one: there was a recent trial in a Crown Court not far from here where the PCT fielded a pharmaceutical adviser as its expert witness. Needless to say, the defence cross-examined her on her knowledge of community pharmacy and elicited that her experience of running community pharmacies, in the 13 years since her qualification, amounted to four separate one-week stints at holiday times. When will PCTs learn that such people are not community pharmacists, and in most cases never have been!

Some other local prescribing advisers driving a local Pharmacy Development Group are trying to exclude experienced LPC community pharmacists from the team. I do not believe th right of exclusion is theirs. Since the main cohort of pharmacists who will be involved in the PDG will be community pharmacists, rather than hospital service emigrants, this does not send the right message.

I am told that they are also trying to use clinical governance a means of disciplining the community pharmacists within their PCTs. When will they learn The community workforce comprises dedicated pharmacist who perform a valuable service, under contract. They are not employees!

The moral is, and with due deference to the politically correc "don't send a boy to do a man's job". It will end in tears.

Northern Ireland NOTEBOOK

Business not for sale

With upwards of 30 pharmacy premises changing hands in Northern Ireland in recent months, there is a slow and subtle change to the pharmacy landscape taking place.

By a combination of low interest rates for those buying, attractive tax breaks for those selling, and the insatiable desire of multiples to acquire more pharmacies, we can see the future shape of retail pharmacy evolving before us.

I've not been approached to sell, but with the uncertainty of what the future holds, and with the opportunity of cashing in on my hard work over many years, I would be very interested in any sensible offers. I would think long and hard before saying no.

Seismic changes are on the horizon. The new pharmacy contract, currently being negotiated in England, will be visited on us in some shape or form. Changes in the way that generics are priced will be imposed, denying us essential income to support our businesses.

A pharmacist who sold up in the mid 1980s was bitter and disappointed

I am convinced that community pharmacists will become, as GPs did in their 1966 contract, health service employees. To many pharmacy contractors this might seem the worst possible scenario.

Yet I'm not so sure... I remember meeting a pharmacist who sold up in the mid 1980s, at the age of 48. When I met him in the late 1990s he was nearing retirement. Witnessing the huge leap in the value of businesses since he sold up, he was bitter and disappointed. His standard of living had declined and he despised working for others.

I won't make the same mistake. I'm here for the long haul. Sorry, I'm not for sale, because it's about much more than money.

Written by a practising Northern Ireland community pharmacist

TOPICAL REFLECTIONS

A missed opportunity

Phenylpropanolamine is now yesterday's news and one of the last products to be re-formulated, Benylin Day and Night, has been re-launched containing pseudoephedrine.

I have always recommended Day and Night as a convenient cold and flu package but have always criticised the product for the sub-therapeutic dose of paracetamol in the tablet. With the change to pseudoephedrine came the opportunity for Pfizer to increase the dosage of paracetamol to 1,000mg, but marketing won over logical therapy.

The recommended dose is still only 500mg of paracetamol four times a day for the Day and Night tablets, whereas if the customer takes the liquid 4-Flu formulation this increases to a therapeutic 1,000mg.

Pfizer has lost the opportunity to re-formulate to achieve a product I really would recommend with confidence. Now I am stuck with the same annoying problem. If I do recommend Day and Night tablets then I will have to continue to laboriously explain to every customer that for full effect they will have to also take one extra 500mg paracetamol tablet four times a day.

Smoke and mirrors with NRT

Before nicotine replacement became available on FP10, manufacturers would compete by a combination of consumer advertising and competitive pricing to the pharmacist. Sales were good, margins excellent and professional involvement vital to maintain customer concordance.

Now my sales have plummeted while NHS prescription usage, particularly of patches, has rocketed. In parallel, customer awareness has decreased and competitive buying is a thing of the past. The supply of nicotine replacement on NHS prescription may be good for the nation's health but it is not financially good for mine.

To add insult to injury the bonuses I used to receive are now to be supplied back to the NHS by an agreed rebate scheme designed to encourage even higher prescribing *(C&D November 23, p7)*.

The health secretary, Alan Milburn, sees this agreement as vital to encouraging PCTs to invest in up-front smoking cessation initiatives, but if it is only the rebate that is re-invested then the overall cost to the NHS of NRT will continue to rise exponentially.

PCTs will link increased funding for smoking cessation initiatives to increased prescribing of NRT but, with no compensatory mechanism to offset the increased pressure on the overall cash limited prescribing budget, cutbacks to other areas of health improvement could be the inevitable result.

A true test of loyalty?

Will a loyalty card scheme for independent pharmacy work *(C&D November 23, p12)*? I would like to believe so, but many years ago I joined a scheme for selling gift vouchers through independent pharmacies and it failed because the customer could see little benefit in giving a gift voucher that was only redeemable through unknown outlets. That scheme quickly died, but loyalty cards are another matter. The plethora of big name schemes suggests that customers do adapt their shopping habits to ensure increased rewards. The fact that customers ultimately fund their own reward by an increase in overall pricing perversely encourages the use of the card, since to not use it costs them twice!

But I must repress my cynicism. I already have a Thursday discount system for pensioners and it does increase turnover on one of my slackest days of the week. I could easily extend this to a loyalty scheme through my existing EPoS tills but it would then only apply to an individual pharmacy. It makes sense to involve thousands of other independent retailers to maximise the customer reward, but before I take the plunge (at 0.3 per cent of turnover it is a not inconsiderable investment) I will await the appraisal I know the NPA will provide for me.

Ple@se e-mail your views to chemdrug@cmpinformation.com

Voyage of Discovery over generic prescribing

Your article about Discovery branded generics *(C&D November 9, p37)* raises some interesting points linking the mechanism of pharmacists' remuneration and the implications of generic prescribing for the NHS.

Prescribing branded generics is certainly not the answer if the NHS is aiming to save money. Widespread use of branded generics, as opposed to true generics, actually costs the NHS more.

While it is true that the Oxactin brand of fluoxctine is cheaper than the *Tariff* price at the moment, it would be short-sighted for PCT pharmaceutical advisors to switch prescribing advice from a generic to a branded product.

Drug Tariff prices eventually fall to reflect market prices and, given the low prices of fluoxetine, it will probably not be long before it falls to a price lower than that of Oxactin. This will then result in a need to reverse previous advice to surgeries, causing confusion all round.

Any PCT advisors with an understanding of community pharmacy, pharmacy wholesaling and the mechanics of the *Tariff* recognise that their time would be much better spent dealing with other drugs which are not in part VIII of the *Tariff*, such as slow release products (eg isosorbide mononitrate SR 60mg).

Mr Kemp suggests that the scheme will not find favour with pharmacists because it affects their bottom line. This is true, but not for the reasons implied. I have no problem with PCTs switching products to more cost-effective ones provided they are readily available.

Your article suggests Oxactin is available through most wholesalers. This is not true. It is not available from all the major full line wholesalers. This means that for me to obtain it I must place a special order, which will not be subject to discount and will involve a handling charge (which I can pass on – although this comes out of the global sum, thus diluting dispensing fees even more).

In short, I will make a loss dispensing Oxactin. I am resigned to the fact that some prescribing changes will reduce my profit. I am against any that will cause me a loss.

I could order direct for distribution through Healthcare Logistics, but this involves minimum quantities, extra work and a delivery delay. What I need is availability in singles and twice a day delivery for these rarely prescribed products. Only a full line wholesaler can give me this.

There is a reason for this lack of availability, and that lies firmly at the door of Discovery. The manufacturer will not allow the wholesalers normal industry standard terms (discount and credit) for these products, thus they are reluctant to stock them. This is understandable.

Sort out the distribution and ensure that pharmacists can buy easily, not dispense at a loss, and they may be more willing to supply the products.

My final point relates to Mr Ballard's comment that profits made by pharmacists from generics are "morally indefensible". This is a bit rich given the 80 per cent margin Discovery is making. It also shows Mr Ballard's ignorance of the way in which pharmacists are paid.

I am very willing to defend generic profits. If pharmacists were to rely solely on dispensing fees paid, the system would collapse tomorrow. Fees do not even cover the wages bill for pharmacy, let alone any other expenses or, indeed, a profit margin!

Contrary to his claim that we are "skimming money out of the NHS" the profits made from generics constitute an integral par of pharmacists' remuneration. This funds the service, a point tha is not lost on the DoH.

Until a more equitable contract is negotiated, generic profits will continue to be an integral part of what the NHS pays towards the provision of a comprehensive pharmaceutical service. The sooner Mr Ballard realises this, th sooner will he cease to alienate th pharmacists who can, and do, influence what GPs prescribe.

Paul Brown
Boston, Lincs

Tim O'Donoghue (left) and John Foreman welcomed the All-Party Pharmacy Group to their pharmacy in Euston, London, last week. Howard Stoate MP, and other members of the APPG, heard how the two pharmacists have transformed the Green Light pharmacy in Drummond Road since they bought it three years ago. Services provided include testing for hypertension, obesity and diabetes as well as medically trained translators to help the local Bengali population. The pharmacy is eagerly awaiting the outcome of its LPS proposal that was submitted to the Department of Health at the beginning of the month. Mr Foreman said this would enable the pharmacy to supply "an enhanced pharmaceutical care service"

Ple@se e-mail your views to chemdrug@cmpinformation.com

CPD for IT pharmacists – what are our registration rights?

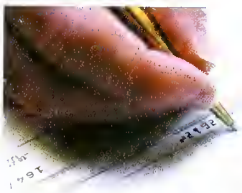
Further to the Kennedy Report, pharmacists, like other healthcare professionals, will soon be required to complete a certain amount of continual professional development (CPD) in order to maintain registration rights. The format of this CPD, and the requirements for different sectors of the profession, have yet to be decided. This process is taking place at the moment.

I am concerned over the plans being discussed by the RPSGB. My concern is not directly over CPD – I have always advocated CPD and truly believe we have a professional obligation to keep up to date – it is more over registration rights.

The exact process by which pharmacists are going to be regulated has yet to be decided but will the system that is implemented be broad enough to encompass pharmacists involved in IT? There has been a suggestion that we will move towards a tiered registration system, meaning pharmacists could only re-register in the sphere in which they are employed. For IT pharmacists, and no doubt others, our lack of patient contact could feasibly take away any claims we may have to being clinical pharmacists and impact on our ability to move back into mainstream practice should we wish to do so.

I have spoken to colleagues, both within and outside the NHS Information Authority, and we are agreed that we need to act now if we are not to be left out of any consultation that the Society might undertake about the future of CPD. If we do not make ourselves heard now, as a small group we could easily be overlooked and the CPD outcome could be unfavourable to our professional practice.

I am trying to contact as many pharmacists in IT as I can – both inside the NHS and in the commercial sector – to build up a group to stand together and take our requirements as specialised pharmacists to the RPSGB consultation. We might all work for different organisations but we have the same responsibility for CPD if we wish to maintain our registered status.



CPD will be required in order to maintain registration rights

To take this issue forward, we need to:

- enter into the current debate on CPD as a cohesive group
- put forward a CPD plan for IT pharmacists which would satisfy the criteria laid down by the RPSGB and fulfil our own requirements as a group.

To help form a consensus on CPD requirements for IT pharmacists I am organising a meeting – probably in February 2003 – for any concerned individuals so that a cohesive message goes to the RPSGB.

Before finalising the date, are there any other pharmacists out there who are interested in this issue? If you are, then please contact me via e-mail on *jo.goulding@nhsia.nhs.uk* as soon as possible.

Whatever your views, the reality is that CPD is coming to pharmacy. It is up to us to make sure that pharmacists in specialised environments are not negatively affected by its introduction.

Jo Goulding
Clinical Terminology author, NHSIA

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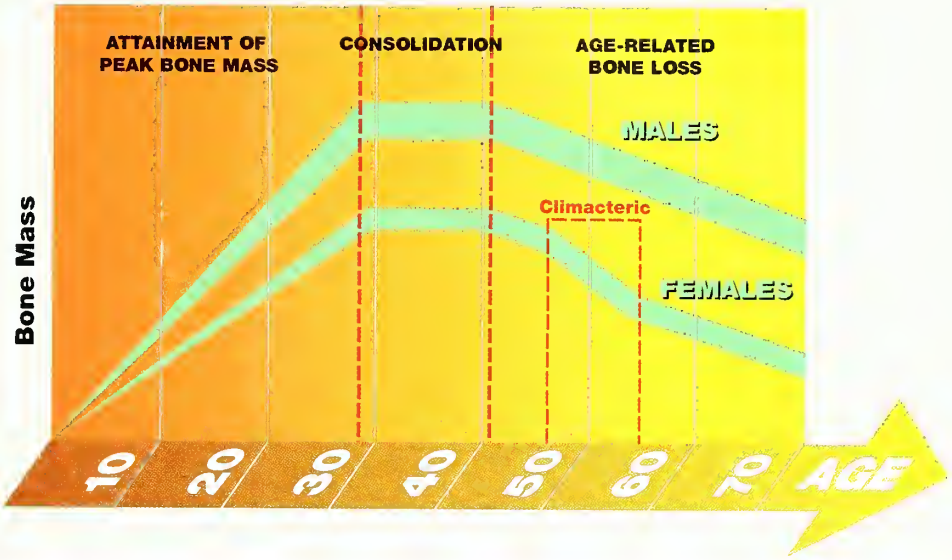
In her second article on HRT, *Nuttan Tanna* answers questions on safety

HRT: risk v benefit

Whether women take HRT or not will depend on the severity of their symptoms and their perception of the risks and benefits. They will ask about alternative treatments and lifestyle changes that could help with symptom control.

All menopausal women considering HRT need to have an individualised risk benefit evaluation before a prescription is written. Due consideration should be given to the patient's medical history, and should include discussion of the patient's preference. It will be the risk-benefit evaluation that will assist the final, informed, patient decision on whether to take HRT or not and for how long.

Fig 1: Schematic representation of lifetime changes in bone mass



The benefits

All HRT preparations in the UK *(Box 2)* are licensed for menopausal symptom control. Classic menopausal vasomotor symptoms include hot flushes and night sweats, affecting sleep, with women often complaining of tiredness, loss of energy, memory loss and depression. Women may also present with vaginal dryness and bladder problems. In the latter case, it is important to remember that urge and stress incontinence could also result from the ageing process, rather than directly as a result of oestrogen loss.

Most HRT preparations contain oestrogen doses that have been shown to help with maintenance of bone density and are therefore licensed for osteoporosis. It is generally true that osteoporosis protection is achieved as long as there is some oestrogen in the systemic circulation.

Higher bone loss occurs during the early years of the menopause.[1] This stabilises, but some loss still occurs in subsequent years *(see Fig 1)*. Lifestyle factors, which should ideally have been in place on a lifelong basis, combined with medical history *(see Box 1)* will determine the risk of future fracture for patients with osteoporosis. Lifestyle factors include adequate weight bearing exercise and a healthy diet, especially with good calcium and vitamin D intake, low alcohol use and smoking status.

Cardiovascular disease

Until recently, based on observational epidemiological studies, it was thought that HRT reduced the incidence of cardiovascular disease. Oestrogen use has been shown to reduce cholesterol, a surrogate marker suggestive of a cardioprotective benefit for HRT.[3] The Nurses' Health Study reported a lower morbidity risk for HRT users compared with non-users.[4] Current hormone users with coronary risk factors such as diabetes or smoking showed the largest reduction in mortality.

However, the HERS study[5], one of the first randomised placebo controlled trials, showed no cardiovascular benefit. 2,763 older postmenopausal women, with a mean age of 67 and established ischaemic heart disease, were studied over 4.1 years. In the first year the HRT group suffered significantly more thrombotic events, but in years three and four there were significantly fewer events.

Results from the Women's Health Initiative (WHI) randomised controlled trial[6] now make it possible to present women with quantitative data to help them assess the risk:benefit ratio for taking HRT *(see Box 3)*. This study was designed to determine the major health benefits and risks of the most commonly used combined hormone preparation in the USA and involved 16,608 women. Participants were randomised to take either conjugated oestrogens 0.625mg with medroxyprogesterone 2.5mg (Prempro), used as continuous combined 'no-bleed' HRT, or placebo.

The trial was planned to last for 8.5 years but was stopped earlier as the number of cases of breast cancer had reached a pre-specified safety limit and overall risks exceeded benefits. The average follow up was 5.2 years.

It should be noted that the study[6] did not consider conditions such as gallbladder disease, diabetes, quality of life and cognitive function. The women recruited to the WHI trial were

Box 1: Some diseases commonly associated with osteoporosis[2]

Endocrine	Rheumatological	Haematological	GI
Hyperthyroidism*	Rheumatoid arthritis	Multiple myeloma*	Malabsorption*
Hypogonadism*	Ankylosing spondylitis	Leukaemia*	Chronic liver disease*
Hyperparathyroidism*			
Cushing's syndrome			

*In patients with osteoporosis of unknown cause, initial investigations should aim to exclude these disorders

Continued on page 22 ▶

Box 2: Hormone replacement therapy (HRT) preparations

Brand	Oestrogen		Progestogen		Presentation	Bleed
Sequential combined therapy						
Adgyn Combi	Estradiol	2mg	Norethisterone	1mg	Tabs	M
Climagest	Estradiol	1mg, 2mg	Norethisterone	1mg	Tabs	M
Cyclo-progynova	Estradiol	1mg, 2mg	Levonorgestrel	0.25, 0.5mg	Tabs	M
Elleste Duet	Estradiol	1mg, 2mg	Norethisterone	1mg	Tabs	M
Estracombi	Estradiol	50mcg	Norethisterone	0.25mg	Patches	M
Estrapak	Estradiol	50mcg	Norethisterone	1mg	Patches & Tabs	M
Evorel-Pak	Estradiol	50mcg	Norethisterone	1mg	Patches & Tabs	M
Evorel Sequi	Estradiol	50mcg	Norethisterone	170mcg	Patches	M
Femapak	Estradiol	40mcg, 80mcg	Dydrogesterone	10mg	Patches & Tabs	M
Femoston	Estradiol	1mg, 2mg	Dydrogesterone	10mg	Tabs	M
Femoston 2/20	Estradiol	2mg	Dydrogesterone	20mg	Tabs	M
FemSeven Sequi	Estradiol	50mcg, 50mcg	Levonorgestrel	10mcg	Patches	M
Novofem	Estradiol	1mg	Norethisterone	1mg	Tabs	M
Nuvelle	Estradiol	2mg	Levonorgestrel	75mcg	Tabs	M
Nuvelle TS	Estradiol	50mcg, 80mcg	Levonorgestrel	20mcg	Patches	M
Premique Cycle	Conjugated oestrogens	0.625mcg	Medroxyprogesterone	10mg	Tabs	M
Prempak-C	Conjugated oestrogens	0.625mcg, 1.25mcg	Norgestrel	150mcg	Tabs	M
Tridestra	Estradiol	2mg	Medroxyprogesterone	20mg	Tabs	Q
Trisequens	Estradiol	2,2,1mg	Norethisterone	1mg	Tabs	M
Trisequens forte	Estradiol	4,4,1mg	Norethisterone	1mg	Tabs	M
All the above incur two prescription charges						
Continuous combined therapy						
Climesse	Estradiol	2mg	Norethisterone	0.7mg	Tabs	X
Elleste Duet Conti	Estradiol	2mg	Norethisterone	1mg	Tabs	X
Evorel Conti	Estradiol	50mcg	Norethisterone	170mcg	Patches	X
Femoston Conti	Estradiol	1mg	Dydrogesterone	5mg	Tablets	X
FemSeven Conti	Estradiol	50mcg	Levonorgestrel	7mcg	Patches	X
Indivina 1mg/2.5mg	Estradiol	1mg	Medroxyprogesterone	2.5mg	Tablets	X
Indivina 1mg/5mg	Estradiol	1mg	Medroxyprogesterone	5mg	Tabs	X
Indivina 2mg/2.55mg	Estradiol	2mg	Medroxyprogesterone	5mg	Tabs	X
Kliofem	Estradiol	2mg	Norethisterone	1mg	Tabs	X
Kliovance	Estradiol	1mg	Norethisterone	0.5mg	Tabs	X
Nuvelle Continuous	Estradiol	2mg	Norethisterone	1mg	Tabs	X
Premique	Conjugated estrogens	0.625mcg	Medroxyprogesterone	5mg	Tabs	X
Gonadomimetic						
Livial	Tibolone	2.5mg			Tabs	X
Unopposed Oestrogens (for women after a hysterectomy)						
Adgyn Estro	Estradiol	2mg			Tabs	
Aerodiol	Estradiol	150mcg			Nasal spray	
Climaval	Estradiol	1mg, 2mg			Tabs	
Dermestril	Estradiol	25, 50, 100mcg			Patches	
Dermestril Septem	Estradiol	50, 75mcg			Patches	
Elleste Solo	Estradiol	1mg, 2mg			Tabs	
Elleste Solo MX	Estradiol	40, 80mcg			Patches	
Estraderm MX	Estradiol	25, 50, 75, 100mcg			Patches	
Estraderm TTS	Estradiol	25, 50, 100mcg			Patches	
Evorel	Estradiol	25, 50, 75, 100mcg			Patches	
Fematrix	Estradiol	40, 80mcg			Patches	
FemSeven	Estradiol	50, 75, 100mcg			Patches	
Harmogen	Estrone	0.93mg			Tabs	
Hormonin	Estriol/Estradiol/Estrone	0.27mg/1.4mg/0.6mg			Tabs	
Menorest	Estradiol	37.5, 50, 75mcg			Patches	
Oestrogel	Estradiol	1.5mg			Topical gel	
Premarin	Conjugated estrogens	0.625mg, 1.25mg			Tabs	
Progynova	Estradiol	1mg, 2mg			Tabs	
Progynova TS	Estradiol	50, 100mcg			Patches	
Sandrena	Estradiol	0.5mg, 1mg			Topical gel	
Zumenon	Estradiol	1mg, 2mg			Tabs	
Adjunctive progestogens						
Adgyn Medro			Medroxyprogesterone	5mg	Tabs	
Crinone			Progesterone	4%	Vaginal gel	
Duphaston HRT			Dydrogesterone	10mg	Tabs	
Micronor HRT			Norethisterone	1mg	Tabs	
Vaginal Oestrogens						
Estring	Estradiol	7.5mcg			Vaginal ring	
Menoring 50	Estradiol	50mcg			Vaginal ring	
Ortho-Gynest Pessary	Estriol	0.5mg			Pessary	
Ortho-Gynest Cream	Estriol	0.01%			Vaginal cream	
Ovestin	Estriol	0.1%			Vaginal cream	
Premarin	Conjugated estrogens	0.0625%			Vaginal cream	
Tampovagan	Stilbestrol	0.5mg			Pessary	
Vagifem	Estradiol	25mcg			Vaginal tabs	

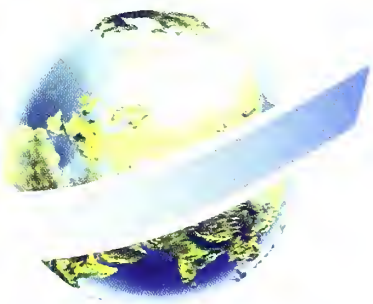
Bleed: M = Monthly Q = Quarterly X = No Bleed

Adapted from *MIMS – Monthly Index of Medical Specialities*

Continued on page 24

Chemist&Druggist

FORMULARY FACTS SERIES



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Neolab Ltd

Chemist&Druggist

FORMULARY FACTS SERIES

Number 7: Ciprofloxacin

The seventh in a series of reference cards for pharmacists

neolab

sponsored by Neolab Ltd

Chemist +Druggist

FORMULARY FACTS

ciprofloxacin

neolab

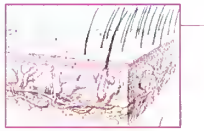
Ciprofloxacin is a synthetic quinolone anti-infective agent with activity against Gram +ve and particularly Gram –ve bacteria

- Treatment of complicated and, in some instances, uncomplicated UTI.
- Oral therapy results in 80-100% cure rate.
- Most treatment failures due to underlying structural abnormalities, indwelling catheters or multi-drug resistance.
- Also drug of choice for prostatitis and stat dose for gonorrhoea (500mg).

ADULT DOSE:

- Treatment of lower respiratory tract infections expressing biological cure of 80-98% in adults.
- Used for bronchitis, pneumonia and bronchopneumonia, sinusitis and occasionally otitis media.
- Not drug of choice for infections due to *S. pneumoniae* or *Ps. aeruginosa*.
- Ciprofloxacin has been employed at high dose for treatment of cystic fibrosis with care for resistant strains and generally, though not exclusively, avoiding use in children.

ADULT DOSE:

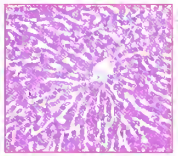


- Effective in cellulitis, abscesses, folliculitis, furunculosis, pyoderma, post-operative wound infections, infected ulcers and burns.
- Can be used as monotherapy for Gram -ve infections, but other agents or combinations should be used for other organisms due to resistance.

ADULT DOSE:

- Has been used for bone and joint infections in adults including osteomyelitis and septic arthritis.
- Clinical response reported at 61-86%.
- Mainly used for Gram -ve aerobic infections.
- Other antimicrobials often added where polymicrobial organisms suspected.

ADULT DOSE:



- Intra-abdominal infections (peritonitis, cholecystitis and cholangitis):
- Febrile neutropenia and immunocompromised patients, usually IV though oral therapy will continue and may cycle with other agents.
- Excellent results in serious sepsis and commonly used in haematology due to spectrum of cover and confidence in bacterial action:

Quinolones are not recommended in children and growing adolescents as they have been associated with arthropathy in weight bearing joints of immature animals. Although the significance of this is unknown in humans, quinolones may be justified for use in special circumstances for short-term use. Ciprofloxacin is licensed for pseudomonas infections in cystic fibrosis (children over 5) and for treatment and prophylaxis of anthrax.

7

FORMULARY FACTS

Ciprofloxacin

Chemist + Druggist

neolab

Ciprofloxacin is a bactericidal antibiotic that inhibits DNA Gyrase. It has excellent bioavailability and its widespread uptake provides for numerous clinical applications. It does, however, have a number of side effects and some clinically significant drug interactions.

Mechanism

- Topoisomerase enzymes are responsible for the coiling of DNA material in both human and bacterial cells. In bacteria this enzyme is called DNA Gyrase.
- When ciprofloxacin inhibits DNA Gyrase, physical disruption follows the loss of supercoiled DNA.
- Exposed genetic material is damaged by enzymes resulting in cell death (bactericidal action).

Side effects

GI: nausea, vomiting, dyspepsia and abdominal pain.

CNS: headache, dizziness, sleep disturbances and seizure.

Skin: pruritis, rashes and photosensitivity.

Tendon damage: at first sign of pain/inflammation discontinue and rest affected limb.
Seek medical advice.

Psychosis: psychiatric or neurological reactions.
Discontinue and seek medical advice.

Severe rash: severe rash, Stevens-Johnson syndrome or toxic epidermal necrolysis.
Discontinue and seek medical advice.

Drug interactions

Epilepsy: risk of convulsions (though *in vivo* evidence not overwhelming).

Warfarin: INR may be doubled due to enhanced anticoagulant effect.

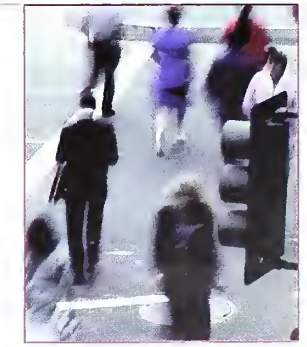
Theophylline: increased theophylline levels may lead to toxicity and convulsions.

Ciclosporin: increased nephrotoxicity.

Clinical use

Ciprofloxacin is used for treatment of inhaled, cutaneous or ingested anthrax (post exposure to *Bacillus anthracis*). This could be as a result of natural or endemic exposure, or bioterrorism. Inhalational anthrax may develop if spore-bearing particles are deposited within alveoli and survive transport to lymph nodes. Cutaneous anthrax may result from introduction of spores though cuts/abrasions.

Recommendations based on US patients following events of last year led to recognition of ciprofloxacin as a first line treatment against resistant strains. Treatment lasts 2-3 weeks for post exposure prophylaxis. For those who contracted the disease, ciprofloxacin and rifampicin were used in combination for 60 days. For children, ciprofloxacin is replaced later in the course with amoxicillin due to fears over long-term use.



OUR NEW GUM TASTES WICKED INSTEAD OF EVIL.

£2.5 MILLION TV SPEND

New Nicotinell Gum is a breakthrough in NRT.

It looks like real chewing gum and tastes really great, so it's designed to help compliance.

Stock up now before our £2.5 million TV campaign breaks.

It needn't be hell with **Nicotinell**
NICOTINE

NELL® FRUIT & MINT 2mg & 4mg CHEWING GUM. Presentations: Nicotine chewing gum containing 2mg ng nicotine, in fruit and mint flavour. **Indications:** Treatment of nicotine dependence, as an aid to smoking n. **Dosage and Administration:** Stop smoking completely when starting treatment. One piece of gum to be when the user feels the urge to smoke. Normally, 8-12 pieces per day, up to a maximum of 25 pieces of 2mg gum or 15 pieces of 4 mg gum per day. After 3 months, the user should gradually cut down the number of pieces Children and young adults: To be used in people under 18 years only on medical advice. **Contra-indications:** okers, occasional smokers. As with smoking, Nicotinell is contra-indicated in acute myocardial infarction, unstable ning angina pectoris, severe cardiac arrhythmias, recent cerebrovascular accident. Pregnancy & Lactation: To be ly on medical advice. **Precautions:** Hypertension, stable angina pectoris, cerebrovascular disease, occlusive penpheral arterial disease, heart failure, hyperthyroidism, diabetes mellitus, fructose intolerance, phaeochromocytoma, renal or hepatic impairment, peptic ulcer or gastric irritation. Keep out of the reach of children at all times. **Side Effects:** Smoking cessation causes many withdrawal symptoms. Events which may be related to smoking cessation include headache, sleep disturbances and gastro- intestinal disturbances. May cause throat irritation, hiccuping, minor indigestion or heartburn. **Legal Category:** GSL. **Product Licence Nos, Trade Price and Suggested Retail Price:** Nicotinell Fruit 2mg Chewing Gum (PL 0030/0162) and Nicotinell Mint 2mg Chewing Gum (PL 0030/0164) in packs of 12 £1.59, £2.79, packs of 24 £3.01, £5.29 and packs of 96 £8.26, £14.49. Nicotinell Fruit 4mg Chewing Gum (PL 0030/0163) and Nicotinell Mint 4mg Chewing Gum (PL 0030/0165) in packs of 12 £1.70, £2.99, packs of 24 £3.30, £5.79 and 96 £10.25, £17.99. **PL Holder:** Novartis Consumer Health, Horsham, RH12 5AB. **Date of Preparation:** September 2002.

older, healthy, postmenopausal women who were asymptomatic *(see Box 4)*.

The authors[6] concluded that Prempro should not be initiated or continued for the primary prevention of cardiovascular disease. Had the WHI trial continued for the planned length of time, it is unlikely that a favourable result for cardiovascular disease would have been achieved. However, the effects of oestrogen on the cardiovascular system may depend on a variety of factors such as the dose of oestrogen and progestogen taken, the formulation used and whether the combination is taken sequentially or continuously.

The HERS 11 follow up study,[7] which looked at whether HRT was beneficial to menopausal women with existing cardiovascular disease, reported negative results, further confirming that HRT should not be prescribed for secondary prevention. Therefore the substantial risks for cardiovascular disease and breast cancer must be weighed against the benefits for fracture prevention when advising patients and selecting preparations to prevent osteoporosis.

It is important to appreciate that the HRT preparation used in the WHI trial[6] is not available in the UK. A similar preparation comprises 0.625mg conjugated oestrogens and 5mg of medroxyprogesterone (Premique). Secondly, as the average age of the women in the WHI trial was 63 (age range 50-79), treatment was not primarily started for menopausal symptom control. Therefore appropriate HRT with the intention to treat short term (two to four years) for symptom control may be continued as in current practice. The risks that need to be considered are the increase in thrombosis with HRT, together with the increase in both coronary heart disease and breast cancer risk with time.

Thrombosis

The background population risk for a thrombo-embolic event in women over the age of 50 is 1 in 10,000 cases. Before publication of the 1997 studies,[5] it was generally thought that HRT did not increase a woman's thrombosis risk. But these studies reported a 2-3.5 fold increased risk of venous thrombo-embolism with HRT use.[5] This usually occurs in the first year, with the absolute risk being small *(Box 5)*.

Breast cancer

The breast cancer risk is currently accepted as increasing over and above the population risk at five years, as indicated in the large 1997 meta-analysis of all epidemiological studies.[7] The population breast cancer risk for women between the ages of 50 to 70 is estimated to be 45 per 1,000, with the risk increasing with age.

The UK National Breast Screening Programme is an NHS funded service for all women over 50; they can have three yearly mammograms until the age of 70. Those few women over 70 who are still using HRT can request recall for mammography. Women should also undertake regular breast examination, and pharmacies can supply leaflets advising on the correct technique.

The excess breast cancer risk was reported to be an extra two and six cases per 1,000 women after five and 10 years, respectively, of HRT use *(Box 4)*. The WHI study[6] is important as it is the first randomised controlled trial to confirm the risk of breast cancer with combined HRT use. This study reported the cumulative hazards function curve for breast cancer risk as rising more rapidly after four years' HRT compared with placebo.[6]

Conclusion

The current evidence suggests that younger menopausal women can use HRT to benefit from vasomotor symptom control. They will need to be supported with an individualised risk-benefit evaluation. While using oestrogen, women gain from maintenance of bone density, prevention of fractures and protection from colorectal cancer. Women should not be prescribed HRT for primary or secondary prevention of cardiovascular disease. There is a slightly increased risk of thrombosis in the first year of HRT use. The WHI study has confirmed an increased risk for strokes.

With use over five years women will have to accept an increased risk of breast cancer if they decide to continue on HRT. The estimated net excess risk over benefit with over five years' usage is one per 230 women between age 50-59 and one per 150 for women aged 60-69.[10] Further randomised controlled trials are needed to assess more definitively the risks and benefits in younger symptomatic menopausal women, to evaluate whether HRT offers a benefit in other conditions such as cognitive function and with a wider range of oestrogen and progestogen formulations.

- Patient information leaflets can be downloaded from the DoH-CSM website to help reinforce the discussion of HRT risks and benefits with women and to explain, for example, how thrombosis presents.

Box 3: The risks and benefits for women treated with combined HRT over five years[6]

– Average age: 63 (age range 50-79)
– Prempro was used in the WHI trial[6]

Condition	Benefit	Risk
	Number of fewer cases per 10,000 women	Number of extra cases per 10,000 women
Coronary heart disease events		7
Stroke		8
Thrombosis events		8
Breast cancer		8
Colorectal cancer	6	
Hip fracture	5	

Box 4: Breast cancer risk linked to oestrogen use

– Background population risk for breast cancer is 45 per 1,000 women between ages 50-70 years
– The background breast cancer risk increases with increasing age

Duration of HRT use	Extra breast cancers per 1,000 women using HRT
5 years	2
10 years	6
15 years	12

Box 5: Venous thrombo-embolism risks

- Risk during pregnancy: 6/10,000 women per year
- Background population risk: 1/10,000 women per year
- HRT - current use: 3/10,000 women per year

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5. HERS. Randomised trial of oestrogen plus progesterone in secondary prevention of coronary heart disease in postmenopausal women. JAMA 1998;208:605-613
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Pharmacist Nuttan Tanna, DComP, PhD, ACPP, is associate director, Pharmacy Practice, Research and Development, the Northwick Park Menopause Clinical and Research Unit

GPs treating eye infections unnecessarily

GPs are treating eye infections with antibiotics even though many of them believe the infection to be caused by a virus and that bacterial infections can be self-limiting.

Researchers at Southampton University questioned 236 GPs about their diagnosis and treatment of acute, infective conjunctivitis (AIC).

More than 90 per cent of GPs responding felt confident or very confident in diagnosing AIC. Topical antibiotics were prescribed by 95 per cent of GPs despite 58 per cent stating that they thought at least half the cases they see are viral in origin. Only 36 per cent thought that they could discriminate between bacterial and viral infections.

The survey found that GPs rarely perform eye swabs or give patient information leaflets. Also, the use of diagnostic symptoms varied enormously for AIC and when distinguishing between bacterial and viral infections.

The authors of the study say that further research is needed to explore the potential benefits and disadvantages of topical antibiotics and to develop microbiological or clinical methods to help GPs target antibiotic prescriptions.

For more information:

Family Practice 2002 Vol 19, No 6, 658-60
www.fampra.oupjournals.org

Childrens' fatal side-effects increasing

The number of suspected fatal side-effects from drugs prescribed to children and reported via the yellow card system has risen over the past decade.

The authors of the study, published in the *Archives of Disease in Childhood*, analysed all reports of a suspected ADR with a fatal outcome reported to the Committee on Safety of Medicines from 1964 until December 2000.

Over that period, 331 children under 16 died, involving 390 suspect medicines.

Anticonvulsant drugs were associated with the highest number of fatalities (65), 31 of these mentioned sodium valproate. Vigabatrin and lamotrigine were associated with 20 deaths. Cytotoxics were associated with 34 deaths, anaesthetic agents with 30 and antibiotics with 29 deaths. Liver failure was the most common cause of death.

The authors of the study said: "We believe that the deaths reported associated with ADRs is likely to be an underestimate, as it is well recognised that these reactions are significantly under-reported."

They also suggested that doctors need to be more aware of guidelines which recommend avoiding medicines in certain high risk groups, eg the use of sodium valproate in children under three, with developmental delays or taking other anticonvulsants.

For more information:

Arch Dis Child 2002;87:462-467
www.archdischild.com

Folic acid may reduce risk of heart disease

Folic acid may reduce the risk of cardiovascular disease by lowering homocysteine levels, according to a study in the *BMJ*.

The serum concentration of homocysteine, an amino acid, is positively associated with the risk of ischaemic heart disease, deep vein thrombosis, pulmonary embolism and stroke.

The meta-analysis of various studies showed that the association between homocysteine and cardiovascular disease is causal.

Decreasing serum homocysteine levels by 3µmol per litre, achievable with a dose of 0.8mg of folic acid, could reduce the risk of ischaemic heart disease by 16 per cent, DVT by 25 per cent and stroke by 24 per cent.

The authors of the study suggest that folic acid could be taken by people at high risk (aged over 55 or with existing cardiovascular disease) or supplied to the public through the fortification of food.

This has already been introduced in the USA to prevent neural tube defects in pregnancy.

For more information:

BMJ, 2002; 325: 1202-6
www.bmj.com

Scriptlines

Co-codamol 15/500 launched

Goldshield Pharmaceuticals has launched a new strength of co-codamol.

Codipar contains paracetamol 500mg and codeine phosphate 15mg per caplet, and is a Prescription Only Medicine.

It is indicated in adults and children over 12 years for the relief of moderate pain.

The dose is one or two caplets every four hours as required. The total daily dose of paracetamol should not exceed 4g (eight caplets).

Price: £7.15

Pack size: 100 caplets
Pip code: 289-6066
Goldshield
Tel: 0208 649 8500.

Eppy eye drops to go

Chauvin Pharmaceuticals is to withdraw Eppy (adrenaline 1 per cent) eye drops due to commercial reasons.

The company expects stocks to last until March 2003.

For more information:

Chauvin Pharmaceuticals
Tel: 01708 383838.

GSK duo discontinued

GlaxoSmithKline is discontinuing Semprex (acrivastine) 8mg capsules and Kemadrin (procyclidine) 10mg per 2ml injection due to low demand.

GSK expects supplies of Semprex to be available until April 2003, and Kemadrin injection until June 2003.

For more information:

GlaxoSmithKline
Tel: 0800 221 441.

NovoNorm interaction

The summary of product characteristics for NovoNorm (repaglinide) has been updated to include an interaction with clarithromycin.

Co-administration may result in increased exposure and enhance the blood glucose-lowering effect of repaglinide, says Novo Nordisk.

For more information:

Novo Nordisk
Tel: 01293 613555.

Once-a-day Sustiva

Bristol-Myers Squibb has launched a once-a-day tablet formulation of its non-nucleoside reverse transcriptase inhibitor, Sustiva (efavirenz).

Sustiva 600, which contains 600mg of efavirenz, is indicated in antiviral combination treatment of HIV-1 infected adults and adolescents over 40kg.

It can be given with or without food.

Price: £224.09

Pack size: 30 tablets
Pip code: 291-5692
Bristol-Myers Squibb
Tel: 01244 586100.

ICaps® focuses on Healthy Eyes

Alcon®, the world's largest eye care company, announces the launch of ICaps Dietary supplement into pharmacy.

Providing essential antioxidants found in healthy eyes and a balance of the eye-carotenoids, Lutein & Zeaxanthin, and other multivitamins and minerals, ICaps is recommended for people at risk from Age-related Macular Degeneration (AMD.)

Risk factors for AMD include:

- **Age (above 40)**
- **Gender (higher risk in women)**
- **Diet & nutrition**
- **Sunlight (light-coloured eyes are more prone to damage)**
- **Smoking**
- **Cardiovascular disease**
- **Heredity (Family history)**

ICaps tablets provide the necessary nutrients to maintain healthy eyes and good visual function. Already recommended by Ophthalmologists and Opticians, ICaps has two unique features that set the supplement apart from other specific eye care supplements:

- ICaps is the only ocular supplement found to have the same nutrient bioavailability equal to four servings of vegetables and fruits per day[1]
- A sustained release formula, for improved absorption and less stomach irritation, which is common in the elderly and with high levels of zinc.
- ICaps is not recommended for children or in pregnancy

ICaps and AMD

Lutein and Zeaxanthin are natural carotenoids, which have been shown through structural and clinical studies to be concentrated in the macular segment of the retina. The body cannot make these carotenoids so accumulation is dependent upon dietary intake. Studies have demonstrated a relationship between dietary carotenoids and the maintenance of a normal healthy macula which is correlated with clarity of the lens of the eye[2]. Lutein & Zeaxanthin exist mainly in green vegetables such as spinach, cabbage and broccoli, but it is not always practical to consume these foods in the amounts recommended. The required amounts can easily be obtained from a daily dose of ICaps.

What is AMD?

Age-related macular degeneration (AMD) is the leading cause of irreversible vision loss in people over 65 in the Western World. It is believed that the number of cases have doubled since the 1950s and is likely to treble over the next 25 years.

AMD occurs when cells in the macula degrade resulting in the loss of central vision, leaving peripheral vision intact, subsequently leading to difficulty with reading, writing and even driving.

In the UK, AMD accounts for 55% of registered blindness. Research shows that as many people again could be registered as blind or partially sighted if they chose to do so. It is believed that at least 300,000 people are suffering from severe sight loss through AMD.[3]

A growing body of research suggests that nutrition plays an important role in AMD. Improving daily diet may slow deterioration from AMD and may reduce blurriness and enhance overall vision. More importantly, diet may help delay or prevent the onset of the condition.

The Age Related Eye Disease Study (AREDS) using a combination of antioxidant vitamims plus zinc, carried out on 3,640 patients over an average of six years, highlighted a 25% reduction in progression to advanced AMD.[4]

A study sponsored by the National Institute of Health in the USA found that people who ate five or more servings of foods rich in Lutein & Zeaxanthin lowered the risk of developing AMD by 43%.[5]

Promotional Support

The launch of ICaps into pharmacy is being supported by Alcon with an educational and promotional campaign targeting both pharmacists and consumers.

Prices ICaps from Alcon are available in one-month packs of 60 tablets. RRP £9.95.

Ordering Details

ICaps can be ordered from major wholesalers.

For further information

Call the Alcon information line on freephone

0800 092 4567

www.luteininfo.co.uk

References:

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Tingle bells, tingle bells...

Thornton & Ross is supporting Virasorb cold sore treatment with a £100,000 festive national advertising campaign on local radio and in regional newspapers from early December to January.

The 'Treat the tingle' campaign is designed to make consumers with cold sores aware of the benefits of seeing the pharmacist at the first sign of a warning lip tingle.

New pharmacy point of sale material for the brand includes a display unit and a *Treat That Tingle* consumer leaflet. A new telephone helpline (0800 6523280) will be set up from December 4 to answer consumer enquiries about cold sores.

For more information:
Thornton & Ross
Tel: 01484 842217.

Cough, cold & flu FORECAST

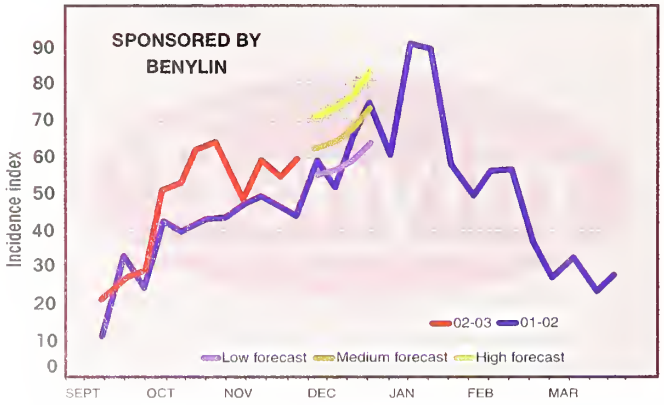
● Cities on Pre-Alert
● Cities on Advisory

KEY FACTS

Benylin

- The levels of respiratory illness across the whole country are considered to be HIGH.
- The levels of all flu symptoms are up at least 25% on the same time last year.
- Cough and Chest Congestion are the most prevalent symptoms across the UK.

Information updated weekly by SDI



Time to check your stock levels!

Look Smart with vibrant hair colour range

A new range of home hair colorants is being targeted at fashion conscious females who are prepared to experiment with colour.

The Smart Beauty range includes five different colour kits and seven vibrant semi-permanent colours.

The kits can be used to achieve colour effects like veiling, undercolour, tips, highlights and duo highlights.

Each kit contains all the necessary accessories from brushes, foils and clips to shampoo, pre-colouring and a step-by-step instruction leaflet.

The semi-permanent colour range comprises shades of purple, red, copper, black, blue, lilac and baby pink.

The range also includes a blonde pre-lightener to give maximum blonding effect and a neutral base for colour.

The products are suitable for European, Asian, Japanese and Afro-Caribbean hair. A consumer advice line (0870 608 9990) has been set up to answer any questions about the products.

Price: from £3.99 for Smart Colour to £5.99 for Smart Duo Highlights
Smart Beauty UK Ltd
Tel: 01708 701344.

Keep your cool over sports injuries

EuropCool is introducing a cooling and compression sports injury recovery system.

Liquid Ice can be applied to a wide variety of injuries such as bruises, strains and sprains. It is especially suitable for areas where it is hard to apply an ice pack. The effects last for up to two hours without the need for refrigeration.

The range includes two recovery bandages – Ice Wrap and Mid Size Ice Wrap – which are pre-soaked in the Liquid Ice solution. The bandages are individually packaged in aluminium foil.

Price: Ice Wrap £6.99, Mid Size Ice Wrap £4.99, Recharger £19.99, Recovery Pack £29.99
Pip code. Ice Wrap 291-5643, Mid Size Ice Wrap 291-5650, Recharger 291-5668, Recovery Pack 291-5676
Europcool Ltd
Tel: 020-8879 0006.

Happiness is a Happinose

The Happinose brand is being extended with the addition of luxury facial tissues.

Designed for sore noses, the soothing balm tissues are packed in an eye-catching bright yellow family pack featuring a smiley face drawing.

An on-pack promotion offers 30p off next purchase.

The Happinose brand will be supported by a national advertising campaign this winter.

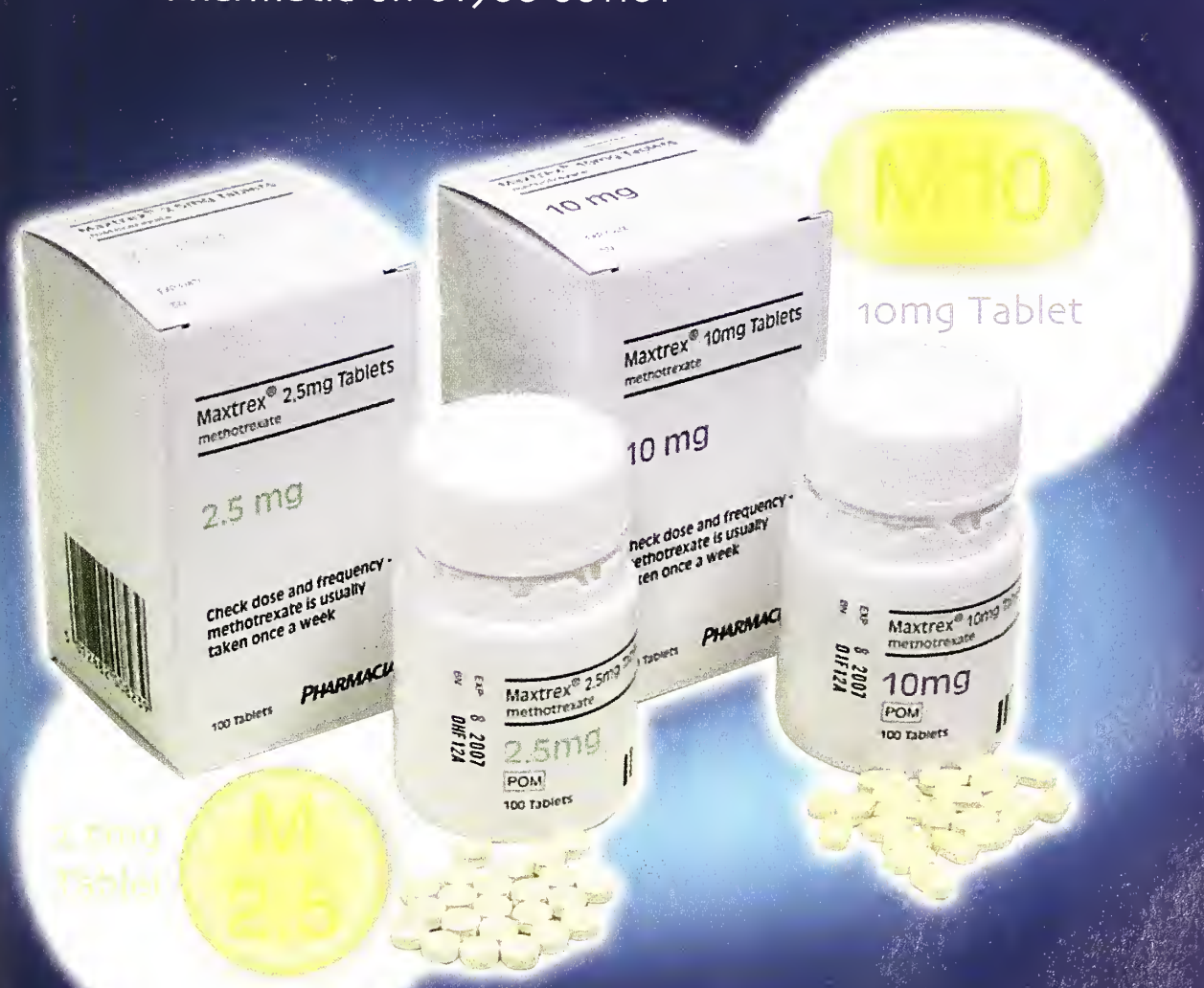
Price: £1.69
Pack size: 90 x 3 ply tissues
Pip code: 290-5743
Georgia-Pacific
Tel: 01942 529000.

Maxtrex®
methotrexate

Visibly Different!

- New shape 10mg tablet -clearly different from 2.5mg
- Clear Weekly Dose warnings on containers and boxes
- Colour coded strength indication on packaging
- Why dispense another methotrexate when you could dispense Maxtrex?

For further information and patient support materials call Pharmacia on 01908 661101



PHARMACIA

Frontshop

Aid to help smokers quit

Rosen Holdings is launching a smoking cessation aid (not available on prescription) to be used as part of a six-week programme.

NicoBloc is designed to gradually modify the behaviour of smokers by reducing the amount of nicotine inhaled per cigarette consumed. The addiction is weakened and eventually broken.

The pack contains a coloured fluid formulated with corn syrup, water, citric acid, preservative and colouring (an FDA food grade formula). The fluid is applied in drops to the filter of the cigarette immediately before smoking.

The number of drops applied is increased from one to three over a recommended three weeks. From week three onwards the smoker keeps using three drops.

Price: £29.45 (two weeks' supply for a 20-a-day smoker)

Pip code: 289-6074
Galpharm International Ltd
Tel: 01226 779911.

Nurse those winter ills

Day & Night Nurse will be back on TV this winter as part of a £1.2 million seasonal marketing support package.

The Night Nurse rain-swept commercial will be on air for two weeks from December 16, followed by another burst in early January.

The end of the commercial will highlight the new Day & Night Nurse Capsules combination product.

A regional radio campaign in the London area will coincide with the first TV burst from mid December.

The range will also be advertised on 2,000 Pharmasite sites nationwide. New point of sale material for the brand features the strapline 'Always on call.'

For more information:

GlaxoSmithKline Consumer Healthcare
Tel: 020 8047 2700.

Teething tots campaign

Reckitt Benckiser is supporting Bonjela Teething Gel with a £150,000 national press campaign.

Advertising will appear in parenting and women's magazines from December until the end of February.

For more information:

Reckitt Benckiser plc
Tel: 01793 732000.

Migraine online advice

Pfizer Consumer Healthcare is launching a Migraleve interactive website to help migraine sufferers manage their condition.

For more information:

www.migraine-advice.com

TV next week

Advanced VO5 shampoo & conditioner: All areas except GMTV
Beechams: All areas except U, CTV
Benylin: All areas except U
Macleans Ice Whitening: All areas except U, CTV
Mark Hill Mobile Straightener: C4, C5, Sat
Multibionta: C4
NiQuitin: U
Nivea AfterShave Balm: All areas
Nivea Hand Age Defying Cream: All areas
Olbas: C5, GMTV, Sat
Panadol ActiFast: U
Sensodyne Total Care: All areas except U,CTV
Sudafed non-drowsy: All areas except U, GMTV
Zantac: All areas except CTV, GMTV
Zovirax: All areas except CTV, GMTV

PharmaSite for next week: Ultra Chloraseptic, Lancashire region, rest **Sudafed** – Window, **Sudafed** – In-store, **Zovirax** – Dispensary

A-Anglia, B-Border, C-Central, C4-Channel 4, C5-Channel 5, CAR-Carlton, CTV-Channel Islands, G-Granada, GMTV-Breakfast Television, GTV-Grampian, HTV-Wales & West, LWT-London Weekend, M-Meridian, Sat-Satellite, STV-Scotland (central), TT-Tyne Tees, U-Ulster, W-Westcountry, Y-Yorkshire

Make sure they're covered in the morning

When smokers are trying to quit, mornings can catch them unawares. Once they've been without nicotine for 6-8 hours, cravings can be intense and hard to resist, which is why many smokers get more cravings in the morning than the rest of the day. Indeed, two out of three smokers light up within 30 minutes of waking.

NiQuitin CQ patches provide nicotine continuously over a 24-hour period, reducing morning cravings compared with a 16-hour patch, for these heavily dependent smokers.[1]

Don't let increased morning cravings increase their risk of relapse. Recommend *NiQuitin CQ* 24-hour patch and help smokers quit from the word go.

Nicotine

The confidence of 24 hour protection

Law Lords rule alcohol ban 'not unfair'

A doctor who was convicted of defrauding the NHS and given three years in jail was not unfairly banned from drinking alcohol by the General Medical Council, Law Lords ruled last week.

The case, which could have implications for any statutory proceedings against other health professionals, involved Dr Timothy Whitefield of Ripon, North Yorkshire, who was convicted in 1995 of conspiracy to defraud by supplying false prescriptions and receiving payments from local pharmacists.

The case had been referred to the professional conduct committee of the General Medical Council which passed on the matter to its health committee. This found that his fitness to practise was "seriously impaired by reason of severe depressive illness" and among conditions placed on his registration were that his alcohol consumption should be limited.

Last November, it was further decided his fitness to practise was impaired "because of his depressive disorder, currently in remission and the harmful use of alcohol". He also had to attend meetings of the doctors'-dentists' group and/or Alcoholics Anonymous and "to abstain absolutely from the consumption of alcohol".

In last week's appeal at the Judicial Committee of the Privy Council, Adrian Fulford QC complained that the ban on alcohol was unreasonable and oppressive. It denied his client the pleasure of even "social drinking" when there was no possibility he would be called upon to perform his professional services and was a breach of the Human Rights Act.

In Article 8 it states: "Everyone has the right to respect for his private and family life, his home and his correspondence." Mr Fulford said the effect of the ban was to deprive him of enjoyment of social drinking "such as on family occasions".

"A person's private life extends to social pastimes outside the home and includes "consumption of alcohol in the local village public house", he argued.

However, in dismissing the appeal, the Law Lords said the Committee had the necessary expertise to reach an informed conclusion. "Thus, it cannot be said that the absolute and total ban on alcohol was either unreasonable or oppressive."

Regarding his human rights complaint, Sir Philip Otton said: "This argument can be disposed of briefly. There is no authority to support the proposition that a ban on the consumption of alcohol is, *per se*, an interference with the right to respect for private life.

"The appellant is not prevented from going to his local public house or engaging in his social life while drinking non-alcoholic drinks."

STATUTORY COMMITTEE

Restoration hearing delayed

A pharmacist who was struck off in June 1995 after he swindled the Halifax Building Society out of more than a quarter of a million pounds must wait to find out if he will be restored to the profession.

Since being struck off, Yash Pal Kansal of Oldham, had been convicted twice, once for falsely claiming to be a pharmacist and once for dispensing controlled drugs while struck off.

Mr Kansal began his application for restoration to the Royal Pharmaceutical Society's Register last week but its Statutory Committee ran out of time and adjourned the case to a future date to be fixed.

Committee chairman, Lord Fraser of Carmyllie QC, said: "These are very serious matters and due to the complexity of the case and time of day, the matter will be adjourned until a later date to be specified."

STATUTORY COMMITTEE

Locum struck off

A locum pharmacist who shocked staff at three separate chemists with his erratic and incoherent behaviour – leaving one fearing for her safety – was ordered to be struck off last week.

Police saw Anthony Farrell of Middleton, Manchester, throwing his luggage out of a hotel window to his girlfriend, to avoid paying bills just hours after being dismissed from the NCC Pharmacy in Alness, Scotland.

The pharmacy had arranged for him to stay at the Morven House Hotel, Alness, with several meals included, whilst he worked for them between January 28 and 31 this year. While at work he was seen by staff leaning on the dispensary bench with his eyes closed only to be woken when the telephone rang, it was claimed.

PC Graeme Erskine told the Society's Statutory Committee that Mr Farrell "was not embarrassed about lying about the hotel" which had refused him further meals or alcohol unless an outstanding £88.70 was paid.

"His feeble excuses showed he was disengaged with reality and a dubious character. He showed no quality or integrity expected of a pharmacist."

Mr Farrell, who did not attend last week's hearing, went on to be dismissed from J Langhorne's Pharmacy, Mytholmroyd, West Yorks, on March 6, having been there for just two days during which time he was seen on all fours swaying from side to side.

A missing methadone prescription was later found by police in Mr Farrell's pocket as he waited at a train station. Pharmacy owner, Jonathan Langhorne, said two other methadone prescriptions were missing as well as diazepam.

The year before, on January 19, 2001, Mr Farrell had been sent home from RC Simpson Pharmacy, Timperley, Altrincham, Cheshire, where he had worked since November, after a staff member was frightened at his erratic and incoherent behaviour.

Shortly after he left the pharmacy police stopped him on the M60 motorway for driving erratically.

On April 20 last year at Bury Magistrates Court Mr Farrell admitted being unfit to drive through drugs on the M60 motorway and was given an interim driving disqualification, 170 hours' community service and ordered to pay £69 costs.

On July 15 this year at Tain Sheriff Court he admitted the theft of £42 from the NCC pharmacy – claiming it was to cover living expenses – and was also convicted of two counts of fraud in relation to not paying hotel bills. He was given two fines of £200 each.

Committee chairman, Lord Fraser of Carmyllie QC, said: "The behaviour at three separate pharmacies is totally unacceptable. We have little hesitation in finding misconduct proved as Mr Farrell is unfit to be on the Register."

STATUTORY COMMITTEE

Alcoholic Devon pharmacist stole tranquillisers

An alcoholic Devon pharmacist was ordered to be struck off on October 14 for stealing tranquillisers just a few months after being caught drink driving.

Neil Henderson did not appear for the five-minute Statutory Committee hearing. In a letter, Mr Henderson, of Bideford, told them: "I will not be attending because my physical health is poor and I am in financial difficulties."

He also revealed that on August 2 he was disqualified from driving for three years and placed on eight months' probation at Barnstaple Magistrates Court for drink driving.

During an earlier hearing the Committee was told police armed with a search warrant had raided Mr Henderson's empty home and seized drugs including a bottle of temazepam elixir taken from his employers. Committee chairman Lord Fraser of Carmyllie QC announced: "We do direct on the basis of the previous findings the removal of his name from the Register."

The Committee had found Mr Henderson unfit to remain on the Register but had adjourned the case until October to read medical reports including his problem with alcohol. Mr Henderson has three months to appeal.

LPS: Where are we now?

Following the second wave of LPS applications, Vanessa Sherwood asks if anyone knows what happens next

Local pharmaceutical service pilots were described as "a new way of organising NHS community pharmacy" in *Pharmacy in the Future* when it was published in September 2000.

With pharmacists still being paid for the number of prescriptions they dispense, rather than the quality of the service they provide, LPS contracts could provide pharmacists in England with an agreed total sum for dispensing and additional services for a distinct group of patients.

LPS pilots are voluntary agreements – not all PCTs have decided to accept bids and not all pharmacists have to be involved.

Guidance from the Department of Health says that pharmacists will also benefit from LPS by:

- making better use of their skills
- allowing pharmacists to work with contracts that they have helped design.

All this sounds great in theory but how are things working out in the real world?

Decision time

The official guidance on how to develop an LPS proposal was launched by the Department of Health at the end of April. With a deadline for the first wave of applications of June 28, pharmacists and PCTs had two months to decide if, and how, they were going to approach LPS pilots. As a result only nine applications were received in time. From these the minister chose four pilot sites, involving six PCTs *(see box)*.

Although PCTs can develop LPS bids they cannot be LPS providers. However, they can work-up LPS proposals and then contract with local pharmacies to provide the services they want. Three out of the four first wave bids were PCT-led.

Successful first wave applications

- Salford PCT
- Central Manchester PCT (on behalf of Central, North and South Manchester PCTs)
- Ashton, Leigh and Wigan PCT
- Northumberland PCT

As the successful first-wave applications were announced the DoH acknowledged "that the short time scale for the preparation of proposals had an adverse effect on the development and detail available in areas where no preparatory work had been done".

Those not accepted for the first wave were encouraged to re-submit after undertaking further work. The Department also said that although many of the proposals that had been approved consisted of the addition of medicines management and a 'salaried service' type remuneration system, it did not mean that this type of system was especially favoured.

With a longer time to draw up schemes it hoped to see proposals which took a more "in the round" look at what pharmacy contracts should cover, including more innovative ideas about remuneration.

Other comments from the Department about applications received said that:

- impact assessments and consultation for all proposals were weak and needed to be improved substantially
- training for LPS providers was weak
- all proposals were weak on evidence for selecting initiatives.

The deadline for second wave applications was November 1. Theresa Prendergast, LPS implementation manager at the DoH, says that proposals for the second wave were received from all four Directorates of Health and Social Care in England and the first part of the assessment process (scrutiny by regional level panels) has commenced. An announcement on two receipt dates for LPS proposals is expected 'soon'.

Impact

PCTs are required to carry out an impact assessment in order that the effect on existing pharmacy contractors can be determined and taken into account when deciding whether or not to grant the application. Concerns about the impact assessments, first raised by the DoH, have been echoed by the PSNC *(see C&D, November 23, p6)* and the NPA, who are highlighting the problem on the front cover of December's issue of *The Supplement*.

This emphasises that the only way the Secretary of State and DoH officials can understand contractors' concerns about an LPS application is from the responses to the impact assessment.

In some cases, pharmacy contractors have not been responding to the PCT consultations, possibly due to very short deadlines. Georgina Craig, head of NHS services development at the NPA, says it would like to see a more structured approach for impact assessments. "Something needs to be done to make the process more uniform," she says. The NPA plans to look at ways it can help PCTs with this, perhaps by developing a 'tool kit' that could be used.

However, Ms Craig says that for future waves of LPS, pharmacy may have an ally in the recently-developed Overview and Scrutiny Committees. Each PCT will have an OSC whose job is to scrutinise substantial variations and developments in health services, and this could include LPS pilots. The OSC has to be given at least three months to scrutinise proposals, leading to a much longer consultation period. This would give pharmacy contractors more time to comment on the PCT's impact assessment.

"It just appears to be another way of introducing medicines management"

Multiple applications

With the resources, staff and time to invest in LPS, how have the larger pharmacy chains approached the pilots?

A spokesman for Boots said: "We want to take part in these pilots because LPS has great potential for patients, and for community pharmacy. Along with other community pharmacies, Boots will be participating in first wave LPS pilot schemes in Manchester PCTs."

Despite some early reservations about the need for LPS, Moss Pharmacy may become involved with the first wave application, as a provider for a PCT-developed bid. It has not submitted any applications for the second wave.

Moss believes that pharmacists should get involved with LPS where opportunities are financially sound and the pilot will be a positive development in pharmacy in the eyes of both health professionals and the public.

Like Moss and Boots, Lloydspharmacy has not worked up any of its own LPS proposals, but may become involved in the central Manchester project depending on the outcome of funding negotiations.

Chris Frost, head of pharmacy services and development at Lloydspharmacy, says: "We see LPS as an opportunity for boosting income in stores with a lower prescription volume."

Overall, however, LPS has not turned out how the company had imagined. "We were open minded, we approached PCTs with what we felt were genuinely innovative services but have been disappointed with the response.

"There have been no innovative first wave applications. It just appears to be another way of introducing medicines management," says Mr Frost. This could be done via a service level agreement with the PCT, without the need for an LPS pilot.

And with many PCTs being involved in either the PSNC's or the National Prescribing Centre's medicines management projects and/or the DoH's repeat dispensing pilots then an LPS pilot may be a project too far.

Umesh Patel, prescribing adviser for the Ashton, Leigh and Wigan PCT, one of the successful first wave bids, says that a good working relationship with local pharmaceutical 'providers' is crucial. "Our approach was around maximising the pharmacist's contribution and moving away from the current method of working, which appealed to most pharmacists." Although the workload is considerable, Mr Patel believes LPS is a "brilliant" opportunity for pharmacists to fully utilise their professional skills.

The DoH may be keen for pharmacists to take on LPS but with the extra work for pharmacists and PCTs, and the uncertainty for contractors awaiting the outcome of the Office of Fair Trading's investigation, pharmacy seems reluctant to get involved.

If the new national contract finally brings the remuneration system the profession deserves, where all pharmacists are paid for providing a quality service rather than the number of prescriptions they can dispense, then will there really be a need for LPS?

Primary colours

Georgina Craig, right, head of NHS service development at the NPA, explains recent changes in PCT governance and explores the implications for community pharmacists

Primary care trusts (PCTs) took over from health authorities to become the main focus for primary care planning and service development in April this year.

The NPA and other national pharmacy bodies have long advocated the need to form links with PCTs and, where possible, for pharmacy contractors to seek appointment to the PCT executive committee (PEC). Indeed, they offer support to help pharmacists achieve this aim.[1,2,3] To date, around 121 of the 320 PCTs have a pharmacist on the PEC and the number is increasing every week.

In March, guidance on the governance of PCTs was published.[4] It outlined changes at both PCT board and PEC level and means PCTs now have greater flexibility in determining their governance arrangements. There is no longer to be a 'national model' of governance, and local PCT boards are able to approve changes to governance arrangements themselves.

This means that if PCTs are keen to appoint community pharmacists to their PEC, it is easy for them to do so. All they need is PCT board approval.

Who is on the PEC?

There will be changes in legislation so that the maximum membership of the PEC can be increased to 18 people. Of these, a total of 14 places are available for professionals. PCTs will decide the make up of the PEC themselves.

The only other stipulations are that there must be at least one general practitioner and one nurse amongst the 14, and no one profession should be "in the majority". GPs are the ones who stand to lose from this since they currently dominate most PECs.

In addition, any professional member can now be elected to the PEC chair (not just a GP). This is a clear attempt by the DoH to open up the PEC to other professions. However, the guidance stops short of making it a requirement for other FHS contractors or health professionals to be represented on the PEC.

It states rather that the professional membership of the PEC must reflect the functions of the PCT and ensure that all health professionals are fully included in planning processes.

The guidance gives a specific example relating to dental services. It states that if the PCT is a provider of dental services then a dentist is expected to be on the PEC. Very few PCTs provide dental services, but some PCTs may interpret this statement to mean that they have to appoint a dentist to the PEC. This is not the case as GPs and nurses are the only ones with a place by right. However, experience shows that pharmacists will probably have to argue this point at local level.

Unfortunately the guidance is a little woolly on the definition of "a majority". It is unclear whether one professional group could dominate among the 14 professional members, but not among the total 18-strong committee.

The NPA believes that diversity of professional representation would be in the spirit of the guidance, but vested interest at local level may lead to continued GP domination of PECs, at least in the short term. The key positions within the PEC are outlined in the panel opposite.

Given that there are now three additional places on the PEC and that pharmacists are specifically named as one of the eligible professions *(see panel)*, there is an excellent chance of a pharmacist getting appointed. In areas where there is already one appointed, there is nothing to stop a second pharmacist standing.

Looking ahead...

Over the coming year many PCTs will be reviewing their governance arrangements in the light of this guidance. Many committees will need t appoint more members to iron out GP majorities. And in others, some PEC members will soon be nearing the end their term of office and will be coming up for re-election.

Pharmacists need to make representations to PCTs straight away note interest in applying to sit on the PEC when vacancies come up.

- Public health input: A new statutory requirement is that all PCTs must hav director of public health sitting on the PCT board. It is up to PCTs to decide how to accommodate this additional place, but it is essential that a lay majority is maintained at board level. There must still be a public health professional on the PEC and, in many cases, the director of public health wil take up this position as well.
- Patients' forums: subject to legislation, a Patients' Forum will be established in every PCT (and NHS Trust). The forum will elect one of its members to serve on the PCT board. addition, this individual will go throug the same formal selection processes as other PCT board members.

Professional leadershi

Guidance makes it clear that all professional staff working within the

"If PCTs are keen to appoint community pharmacists to their PEC, it is easy for them to do so"

PCT must have clear lines of managerial and professional accountability and clear, accessible routes for professional support, training and leadership. GPs and other FHS contractors (and this includes community pharmacy contractors) should have access to identifiable professional leads. PEC members therefore have an important role in professional leadership.

Up until now, few PCTs have recognised the need to provide professional support, training and leadership for pharmacy contractors – mainly because pharmacy contracts were still "held" at health authority level. This changed in October when PCTs assumed responsibility for pharmacy NHS contracts as well.

The need for this support is another good reason for appointing a community pharmacist to the PEC in areas where applications have not been successful so far.

However, if PEC pharmacists are to take on such a leadership role, they will need to have additional time funded to do so. Alternatively, a pharmacist employed by the PCT might take on this role.

In these circumstances, the pharmacist must be able to demonstrate that he/she is competent to provide professional leadership to community pharmacists (for instance, have experience of working in the sector), and a community pharmacist representative should arguably be involved in the appointment process.

Covering the cost

The final issue of importance is that the allowances payable to members of the PEC were increased, effective from April 1, 2002. PCTs, through their remuneration committees, will have flexibility to vary these if necessary to meet local circumstances.

But suggested levels of remuneration for executive committee members (time commitment of three days per month) are £5,968 (annual fee) and £4,521 (locum payments). Pharmacists should be paid similar fees.

The conditions have never been better for pharmacists to make the case for appointment to the PEC. There will be free places and pharmacists have a strong case to make. Taking on this role brings both personal and professional rewards. If you have the time to commit to the role, consider an application.

The NPA's NHS Service Development team has produced a pack to help pharmacists preparing for interview for appointment to PECs. If you are thinking of applying, contact the NPA on *nhs.dev@npa.co.uk* or 01727 858687 ext 217 or 376.

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Who is on the PEC?

DoH guidance says the following people should constitute the PEC:

- PCT chief executive
- director of finance
- at least one social services representative nominated by the local authority
- a public health professional, eg consultant in public health medicine, in dental public health or other specialist
- up to 14 healthcare professionals – at least one GP and one nurse – plus allied health professionals, dentists, pharmacists, optometrists, consultants (no one professional group to be in the majority).

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For the inhabitants of that bulwark of the Med, Gibraltar is getting a pretty shabby deal from Westminster at the moment.

This month's referendum in the colony produced a result that Messrs Blair and Straw will find hard to ignore, namely that the inhabitants of the Rock do not want Spain to have any say in its government.

Of course, Gibraltarians are proudly pro-Britain (for what reason is not clear as it seems our PM is keen to end sole British sovereignty of the outpost and instead share responsibility with the Spanish, who signed away their claim 300 years ago).

Among the thousands of locals taking part in the referendum (which saw about 17,900 vote for the status quo and only 187 for change) was pharmacist Louis Calvente. He is pictured in rather Churchillian mode while awaiting the outcome of the vote in Casemates Square, downtown Gibraltar, where his pharmacy is.

Pharmacist Louis Calvente, left, and Michael Hedgman from Stoke Poges

Accompanying him is Michael Hedgman, whose pharmacy is a little further away, being the Hedgerail Pharmacy, Stoke Poges, Buckinghamshire.

"Mr Calvente is an extremely well known and respected citizen of Gibraltar," says Mr Hedgman, "and so being a friend and associate of his, I was invited to give my views on the sovereignty proposals on Gibraltar television."

Referendum night must have been a spectacular sight – perhaps the Last Night of the Proms should move there, now that the Brits seem too politically correct to wave a Union Flag while listening to that great patriotic song, 'Yes we have no bananas'.

A New York frame of mind

While not taking a New York minute, West Country pharmacist and Avon LPC secretary Stuart Moul has managed to complete the New York marathon in a smidgen over four hours.

Having been bitten by the marathon bug in the London event *(C&D April 27, p46)*, Stuart left his four pharmacies in Bristol to take part in the big run in the Big Apple earlier this month. He has managed to raise £1,200 through sponsorship for the local charity Bristol Cancer Help Centre.

"Running in the London Marathon was a tremendous experience, but I was told that the New York marathon was even better," enthused Stuart.

"I really had to find out if that was true! Running through the Boroughs of Staten Island, Queens, Brooklyn, Manhattan and The Bronx was a unique way to see parts of New York you would never otherwise see."

A word of advice for anyone thinking of following in Stuart's footsteps: the going gets tough, especially along First Avenue.

"It seemed to go on forever," he says. Asked if he would do it again the answer is an emphatic: "Never. But there is always the Sydney Marathon next year."

Watch this space!

Stuart Moul in the New York Marathon, earlier this month

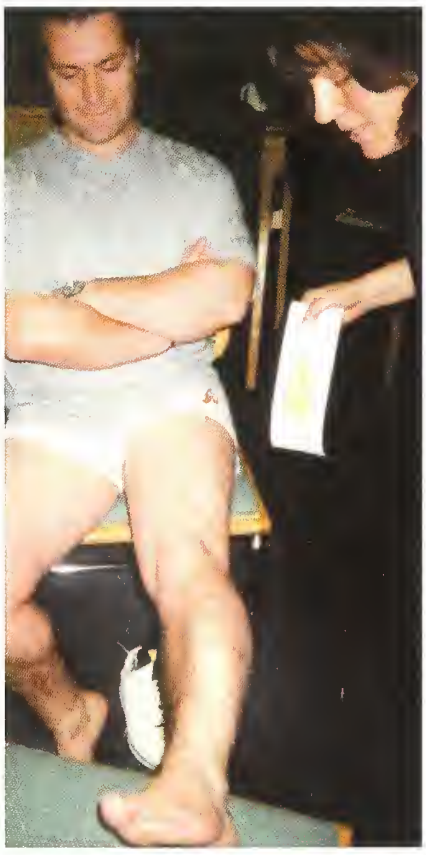
Genus man waxes lyrical for Children in Need

Never let it be said that senior managers shy away from doing their bit for charity, even if it involves the sort of pain men are usually blissfully unaware of.

As part of a fundraising event for Children in Need, Peter Ballard, Genus's sales and marketing director, put on a brave face and gritted his teeth as staff waxed his legs and shaved his head.

"It is always nice to see a manager squirm for a change," said Louise Banks, a business analyst at Genus (never had you down as squeamish, Peter).

Staff also paid a fee for being allowed to turn up for work in their pyjamas. A total of £150 was raised.



Right: Peter Ballard takes his punishment like a man...

Just reward

Judging by the number of biscuit tins, cakes and homemade mince pies that appear in dispensaries at this time of the year, community pharmacists are well aware that good manners and a little courtesy can make a lasting impression.

And sometimes you might hit the jackpot big time, as one Joseph Parisi, editor of the Chicago-based magazine *Poetry*, discovered.

During the early 1970s, an amateur poet, Ruth Lilly, began submitting work to the magazine. But the editor found it unsuitable and courteously returned it.

His courtesy paid off. Unbeknown to him, Ms Lilly just happened to be the last surviving great-grandchild of Eli Lilly and billionaire heiress to the family firm.

She bequeathed the magazine a nine figure sum, as much as $150 million, according to some estimates.

Mr Parisi said: "I treated her as I would treat anybody."

A moral to us all.

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